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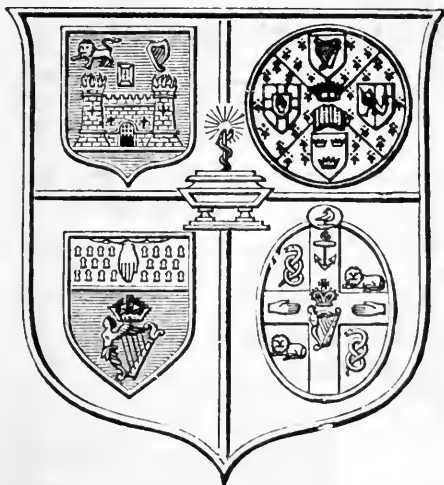
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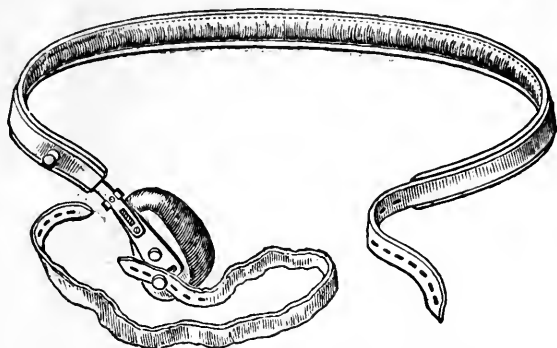
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AUGUST 1, 1898.

PART I.

ORIGINAL COMMUNICATIONS.

ART. VI.—*Clinical Report of the Rotunda Lying-in Hospital, for One Year, November 1, 1896, to October 31, 1897.* By R. DANCER PUREFOY, M.D., Master; T. HENRY WILSON, HENRY JELLETT, R. P. R. LYLE, Assistant Masters.

(Continued from page 26.)

TABLE II.—SPECIAL OPERATIONS.

Perineorrhaphy—

Lawson Tait's	-	-	-	37
Sänger's	-	-	-	6
Lawson Tait's (for complete rupture)	-	-	-	4
				<hr/> 47

Anterior colporrhaphy	-	-	-	17
-----------------------	---	---	---	----

Colpo-perineorrhaphy—

Hegar's	-	-	-	22
Martin's	-	-	-	3
				<hr/> 25

Trachelorrhaphy—

Emmet's	-	-	-	8
Sänger's	-	-	-	5
				<hr/> 13

Amputation of cervix—

Schröder's	-	-	-	25
Circular	-	-	-	1
				<hr/> 26

Excision of benign growth from cervix	-	1
Schultze's treatment of adherent retroversion	-	4
Posterior division of the cervix	-	25
Marion Sims' operation for cervical carcinoma	-	2
Plastic operation for recto-vaginal fistula	-	1
Vaginal cœliotomy—		
Hysteropexy	-	2
Hysterectomy	-	2
„ (by morcellement)	-	2
Ovariectomy	-	2
Exploratory	-	3
		— 11
Ventral cœliotomy—		
Panhysterectomy	-	9
Ovariectomy	-	14
Salpingo-öophorectomy	-	21
Miscellaneous	-	7
Exploratory	-	4
		— 55

Posterior Division of Cervix (or Marion Sims' operation) was performed, according to Dudley's modification; twenty-five times—once for cervical elongation in a nulliparous woman; fourteen times for pathological ante flexion; or [and] stenosis of the uterine canal, occurring in married women whose chief symptoms were sterility, or [and] dysmenorrhœa; and ten times in unmarried women, with a similar condition, but whose chief symptom was dysmenorrhœa.

Schröder's Amputation of the Cervix was performed twenty-five times—eighteen times for laceration, associated with hypertrophy, or [and] erosion; five times for hypertrophy, unassociated with laceration; and twice for erosions occurring in unmarried women.

VAGINAL CŒLIOTOMIES.

CASE 11.—Owing to extensive ulceration of the cervix the actual cautery was freely used before the operation was commenced. The body of the uterus was small, and there was no difficulty in removing it. There was some thickening in the broad ligaments, and clamps were used; the clamps were removed on the third day. She died on the seventh day, when the temperature ran up to 104° F., with almost total suppression of urine. Pain continued

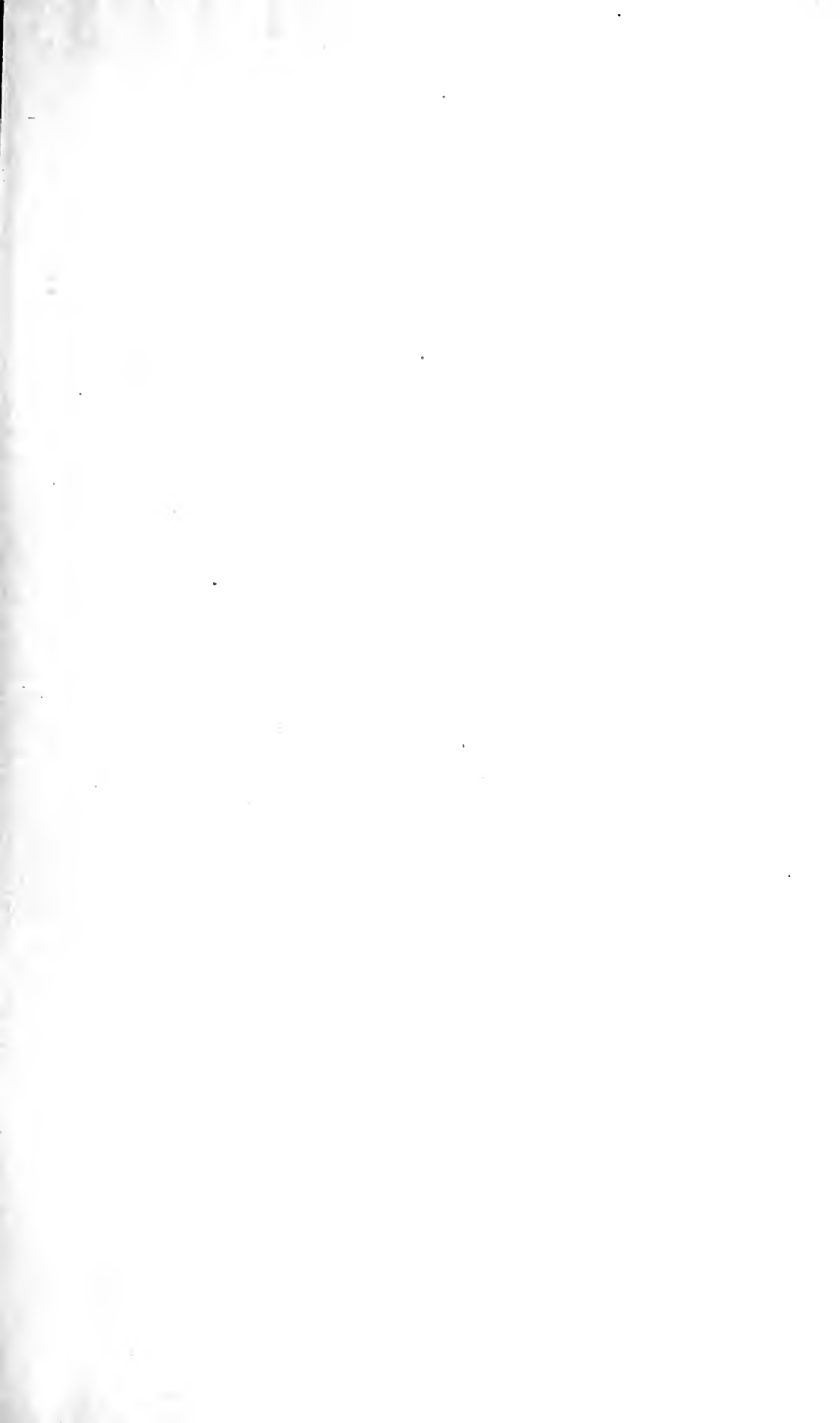




PLATE VII. (Diagrammatic).—Ovarian Fibro-cystic Tumour
simulating Pregnancy.

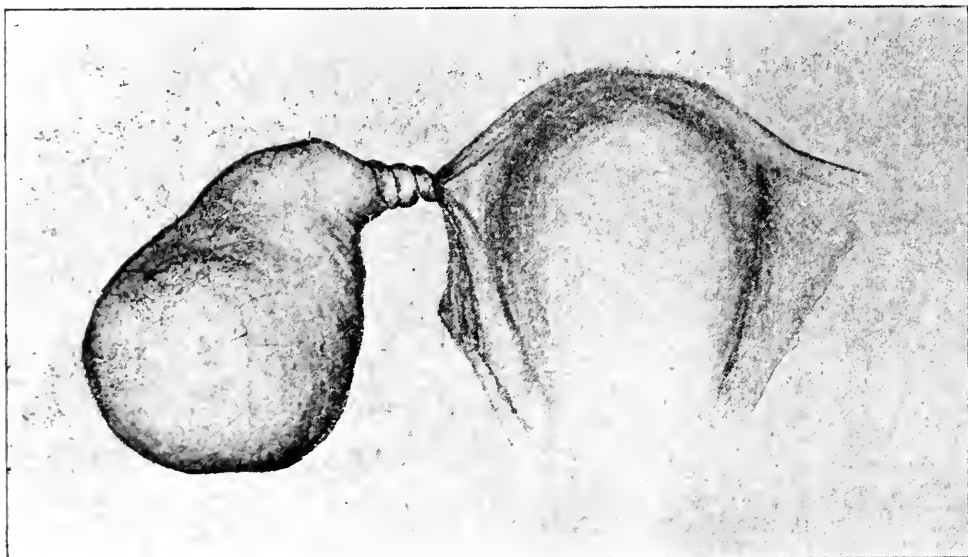


PLATE VIII.—Pyosalpinx with twisted pedicle.

all along, and on the day before death there was some foul-smelling discharge from vagina. *Post-mortem* showed some sloughing where the clamps had been applied, which extended to the pelvic peritoneum; the kidneys were granular and contracted, and were probably the primary cause of death. As the latter did not occur during the clinical year, it is not included in the list of deaths.

OVARIOTOMIES.

CASE 14.—Tumour was the size of a full-time pregnancy; was separate from the uterus; partly cystic and partly solid; the solid part resembled a foetal head felt through liquor amnii. The cyst contained a large quantity of dirty black fluid; there was no trouble removing it. (See Plate VII.)

SALPINGO-ÖOPHORECTOMIES.

CASE 2.—The stitches were removed on the eighth day. During the night she had a severe fit of coughing, and when seen in the morning the wound was found opened, the intestines having escaped under the dressings. She was anæsthetised and the dressings were removed, when it was found that about three feet of the intestine was protruding and was adherent to both skin and dressings. The adhesions were separated, the protruding intestine thoroughly cleansed with boric lotion, the abdomen irrigated with same lotion, the edges of the wound vivified and resutured. The patient made an uninterrupted recovery.

CASE 4.—This is a rare condition; the pedicle was twisted three times on itself, as shown in illustration. (See Plate VIII.)

CASE 15.—It was first attempted to remove this tumour by vaginal cœliotomy, but on account of dense adhesions the operation was abandoned, and eleven days later ventral cœliotomy was performed. The tumour, together with right tube and ovary, was removed, and proved to be a hydrosalpinx about the size of a kidney. Convalescence normal.

CASE 16.—During the breaking down of adhesions which bound a tumour—probably a dilated tube, in Douglas' pouch—some pus escaped into the pelvic cavity; the mesentery was also adherent in this region. The tumour was removed with difficulty along with an ovarian cyst, size of an orange, and a parovarian cyst (?) was shelled out from the posterior aspect of the right broad ligament. The pelvis was wiped out, Mikulicz bag inserted, and abdomen

closed. After the removal of the bag pus continued to come from the pelvic cavity for a considerable time and it was found necessary to introduce a glass drainage-tube to prevent the wound closing on the surface. This probably caused the development of a fæcal fistula which occurred a fortnight after the operation. This had almost closed when the patient left hospital, against advice, two and a half months after operation. She has been seen several times since, and is now perfectly well.

CASE 18.—Last confinement, March 12th, 1897. Menstruated seven weeks later, followed by amenorrhœa for two months. At the end of July had a hæmorrhage, which lasted half-an-hour, with bearing-down pain; was found on examination, on August 16th, to have a tumour filling Douglas' pouch adherent to uterus, which was somewhat enlarged. On August 31st this tumour was removed by ventral cœliotomy; the uterus was the size of a four months' pregnancy, and—as it was doubtful whether it was not due to a soft myoma—the right tube and ovary were also removed. This proved to be an ectopic gestation of the left side; when examined before being discharged on the 28th September the uterus was the size of a five months' pregnancy, which was diagnosticated. She has since written from the country that she was delivered on the 24th October of a premature child, which lived only a few hours.

CASE 19.—Admitted with history of amenorrhœa for two months, followed by hæmorrhagic discharge and pain for five weeks. She was suddenly seized on her second night in hospital by severe pain in the abdomen, accompanied by vomiting. Rupture of the tube was diagnosticated; the abdomen was opened, and a ruptured tubal pregnancy, from which a large quantity of blood-clot had escaped into the abdominal cavity, was removed. Patient made an uninterrupted recovery and left hospital four weeks later.

CASE 20.—This patient aborted ten weeks previously and since had had two normal menstrual periods. She sought admission to hospital for hæmorrhage, lasting for a fortnight. The tumour was the size of an orange and the corresponding ovary was cystic. (See Plates IX. and X.)

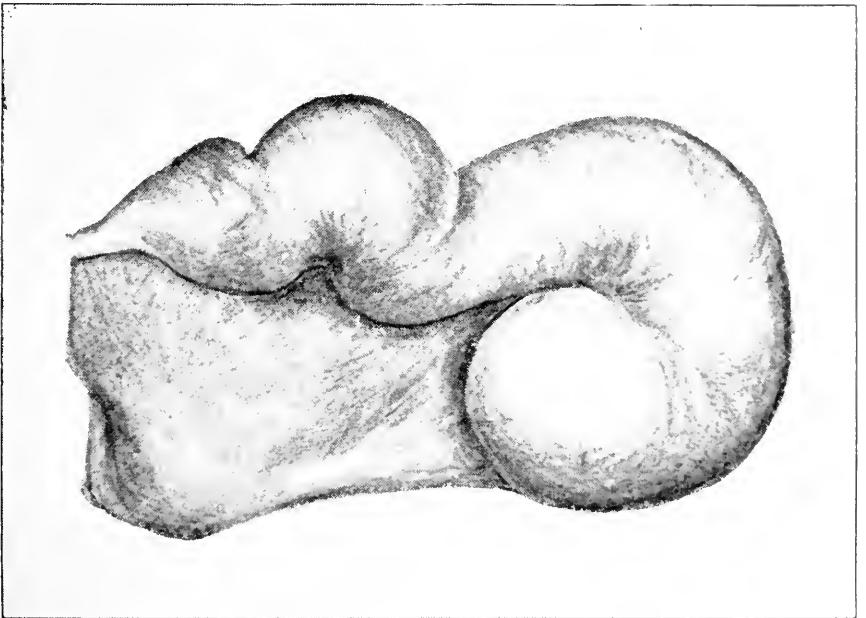


PLATE IX.—A case of Pyosalpinx.

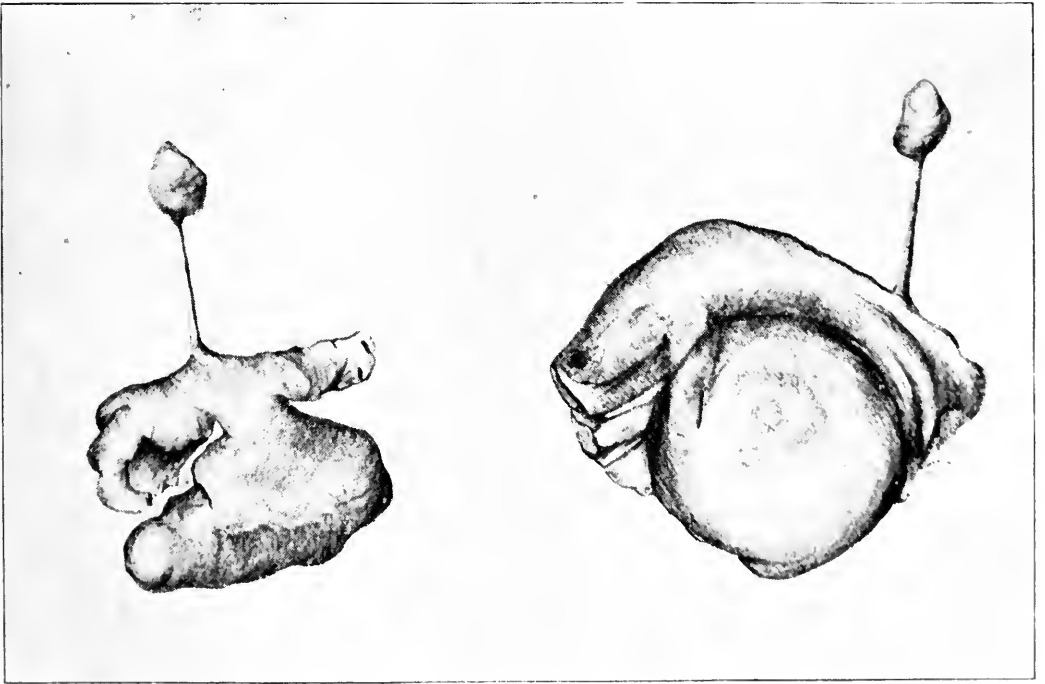


PLATE X.—A case of Double Pyosalpinx with Hydatids of Morgagni.

TABLE III.—VAGINAL CÆLIOTOMIES.

No.	Name	Age	Disease	Operation	Result	REMARKS
1	M. M.	36, M.	Prolapsus uteri	Mackenrodt's vaginal fixation	Cured	—
2	S. A.	49, M.	Multinodular myoma.	Doyen's morcellement	Cured	—
3	K. W.	47, M.	Procidentia uteri	Mackenrodt's vaginal fixation	Cured	—
4	M. M.	38, M.	Intra-cervical carcinoma and myoma	Hysterectomy	Cured	Seen twelve months later. She says she never enjoyed better health.
5	E. H.	41, S.	Ovarian cirrhosis	Double ovariectomy	Cured	Operation difficult on account of short ligament and narrow vagina.
6	L. G.	26, M.	Hydrosalpinx	Exploratory	—	See Table VI., Case 17.
7	J. C.	34, M.	Myoma	Doyen's morcellement	Cured	—
8	J. N.	40, W.	Tubercular disease of peritoneum	Exploratory	Relieved	Caseous nodule removed and found tubercular.
9	K. W.	27, M.	Dermoid cyst	Left ovariectomy	Cured	Cyst contained a quantity of hair.
10	L. D.	28, M.	Ovarian cyst	Exploratory	Relieved	Cyst too adherent to be removed. Patient examined twelve days later; cyst had disappeared. <i>Vide supra.</i>
11	M. M. C.	48, M.	Cervical carcinoma	Hysterectomy	Died	

VENTRAL CELIOTOMIES.

TABLE IV.—PANHYSTERECTOMIES.

No.	Name	Age	Disease	Result	REMARKS
1	M. M'C.	40, M.	Large cystic myoma	Died	Tumour weighed 16 lbs. <i>Vide infra</i> , under "Deaths."
2	E. M.	37, M.	Large myoma	Cured	Size of 6½ months' pregnancy. Confined six months previously.
3	S. M'N.	30, M.	Large myoma	Cured	Size of 7 months' pregnancy.
4	R. H.	33, S.	Fibro-cystic myoma	Cured	Size of 6 months' pregnancy.
5	K. M.	40, M.	Myoma	Cured	Size of 4½ months' pregnant uterus.
6	M. N.	46, M.	Myoma	Died	Size of large foetal head. <i>Vide infra</i> , under "Deaths."
7	R. L.	50, M.	Large myoma	Died	Extended to ensiform cartilage. <i>Vide infra</i> , under "Deaths."
8	M. P.	36, M.	Myoma	Cured	Extended to umbilicus.
9	W. B.	32, S.	Large myoma	Cured	Weighted 12½ lbs.; capsule very vascular.

TABLE V.—OVARICTOMIES.

No.	Name	Age	Disease	Operation	Result	REMARKS
1	M. D.	29, M.	Dermoid of both ovaries	Double	Cured	Each size of Tangerine orange.
2	B. D.	37, M.	Multilocular ovarian cyst	Left	Cured	Size of seven months' pregnancy.
3	M. R.	48, M.	Ovarian cyst	Left	Cured	Size of seven months' pregnancy.
4	M. C.	22, S.	Ovarian cyst	Right	Cured	Extending to umbilicus.
5	E. M.	28, M.	Ovarian cyst	Right	Cured	Size of an orange; adherent to intestines by firm adhesions, which required division with the scissors; peritoneal coat of intestine stitched in several places; convalescence normal.
6	A. C.	26 M.	Ovarian cyst	Left	Cured	Size of foetal head.
7	M. A. J.	60, W.	Ovarian cyst	Right	Cured	Size of seven months' pregnancy; cyst thick-walled, containing thick mucoid fluid.
8	M. G.	50, S.	Multiple myomata	Right	Cured	Left ovary atrophied.
9	M. M. D.	54, S.	Multilocular ovarian cyst	Right	Died	Size of full-term pregnancy. <i>Vide infra</i> , under "Deaths."
10	M. M.	50, W.	Glandular tumour of ovary	Right	Cured	Size of seven months' pregnancy.
11	S. S.	50, S.	Fibro-myoma of ovary	Right	Cured	Size and shape of a large saucer, two inches thick; pedicle, narrow band 6 inches long; myomectomy in addition; calcified myoma size of hen's egg.
12	E. M.	36, M.	Ovarian cyst	Left	Cured	Size of tennis ball.
13	A. B.	19, S.	Ovarian cyst	Right	Cured	Cyst size of 4½ months' pregnancy; tapped before removal.
14	A. S.	33, M.	Ovarian cyst	Right	Cured	Simulated pregnancy. <i>Vide infra</i> .

TABLE VI.—SALPINGO-OÖPHORECTOMIES.

No.	Name	Age	Disease	Operation	Result	REMARKS
1	H. C.	47 S.	Benign adenoma	Left	Cured	<i>Vide supra.</i>
2	T. M'K.	32 M.	Double hæmatosalpinx	Double	Cured	Right tube adherent in Douglas' pouch, ruptured on manipulation, with escape of two large blood clots; left tube diseased; abdomen irrigated.
3	B. E.	25 M.	Right hæmatosalpinx	Double	Cured	Twisted pedicle. <i>Vide supra.</i>
4	M. B.	18 M.	Pyosalpinx	Left	Cured	Left parotitis on fourth day. Suppuration in parotid gland on tenth day, which detained her in the hospital till the fifth week.
5	E. M.	28 M.	Dilated tube and cystic ovary	Left	Cured	Cyst size of five-months' pregnancy, with a twisted pedicle.
6	M. J. C.	40 M.	Ovarian cyst and hæmatosalpinx	Right	Cured	Was detained in hospital for a considerable time owing to purulent discharge from abdominal wound; twelve months later patient in good health.
7	M. A. O'B.	37 M.	Tubercular ovary and tube	Right	Cured	<i>Vide infra</i> , under "Deaths."
8	E. W.	36 S.	Multiple myomata	Double	Died	Abdomen irrigated. Patient markedly jaundiced on third day, which lasted two days.
9	R. G.	26 M.	Ruptured hæmatosalpinx	Right	Cured	Small sinus in abdominal wound. Four months afterwards a piece of silk came away, and sinus persisted for more than nine months after operation
10	N. W.	20 M.	{ Right hæmatosalpinx } { Left pyosalpinx }	Double	Cured	

11	M. R.	28 M.	Ruptured tubal pregnancy	Left .	Cured	Tumour filled the whole of Douglas' space, and had ruptured.
12	F. C.	23 M.	Adenoma of both tubes .	Double	Cured	
13	M. K.	30 M.	Double pyosalpinx .	Double	Cured	Left tube matted in Douglas' pouch, with a piece of omentum and a coil of intestine. In separating adhesions intestine was injured, and was stitched.
14	A. M'G.	40 M.	{ Double pyosalpinx } { and ovarian cyst }	Double	Cured	Cyst of considerable size filling lower part of abdomen. Some pus had escaped from the tubes into the pelvis.
15	L. G.	26 M.	Hydrosalpinx .	Right .	Cured	<i>Vide supra.</i>
16	M. L.	27 M.	{ Double pyosalpinx } { Ovarian cyst } { Parovarian cyst }	Double	Cured	<i>Vide supra.</i>
17	K. R.	26 M.	Cystic ovaries and enlarged tubes	Double	Cured	Left ovary size of a large egg, and attached to the uterus by vascular adhesions which gave considerable trouble during operation.
18	A. F.	34 M.	Left tubal pregnancy .	Left .	Cured	Concomitant uterine pregnancy. <i>Vide supra.</i>
19	M. A. B.	30 M.	Ruptured tubal pregnancy	Right .	Cured	<i>Vide supra.</i>
20	J. W.	34 M.	Ruptured tubal pregnancy and cystic ovary	Right .	Cured	<i>Vide supra.</i>
21	H. T.	30 M.	Enlarged tubes and ovaries	Right .	Relieved	Uterus myomatous—appendages very firmly adherent posteriorly.

TABLE VII.—MISCELLANEOUS.

No.	Name	Age	Disease or Condition	Result	REMARKS
1	A. M.	56, M.	Ventral hernia .	Cured .	Following cœliotomy four years previously.
2	M. S.	34, M.	Ventral hernia .	Cured .	Following cœliotomy three years previously.
3	A. T.	27, M.	Umbilical epiplocele .	Cured .	Following confinement five years previously. Surface had commenced to ulcerate.
4	I. B.	39, M.	Ventral hernia .	Cured .	Following cœliotomy six years previously. Three confinements in the meantime.
5	L. C.	26, M.	Large abdominal abscess	Died .	<i>Vide infra</i> , under "Deaths."
6	C. M.	49, M.	Myoma .	Cured .	Size of six months' pregnancy. Myomectomy.
7	M. B.	30, S.	Multiple myomata .	Cured .	Two pedunculated myomata, size of oranges, ligatured and removed. Abscess in left broad ligament burst during removal. Convalescence normal. Great hypertrophy of cervix, which protruded from the vulva, amputated five weeks subsequently.

TABLE VIII.—EXPLORATORY.

No.	Name	Age	Disease	REMARKS.
1	M. P.	22, M.	Acute general peritonitis .	Abdomen opened and irrigated. Patient died same night. <i>Vide infra</i> , under "Deaths."
2	B. G.	55, M.	Malignant tumour (?) .	Tumour extended from the pelvis to three inches above the umbilicus, and was universally adherent. No attempt at removal.
3	E. O'H.	20, M.	Adherent retroversion, causing severe pelvic pain .	Fundus bound to rectum by old, firm adhesions. In breaking these down there was free hæmorrhage, controlled by continuous suture. Appendages normal.
4	C. B.	50, M.	Calculus in ureter (?) .	Removal failed. <i>Vide infra</i> .

TABLE IX.—DEATHS.

No.	Name	Age	Disease	Operation	Cause of Death
1	B. F.	56, M.	Multiple myomata	Panhysterectomy	Bronchitis.
2	M. M'C.	40, M.	Large cystic myoma	Panhysterectomy	Shock.
3	M. F.	32, M.	Endometritis	Curetted; iodine injected	Acute sepsis.
4	E. W.	36, S.	Multiple myomata	Double salpingo-öophorectomy	Intestinal obstruction.
5	M. P.	23, M.	Acute general peritonitis	Abdominal cavity opened and washed out	Septic peritonitis.
6	M. M'D.	54, S.	Multilocular ovarian tumour	Ovariectomy	Septic pneumonia.
7	M. N.	56, M.	Myoma uteri	Panhysterectomy	Intestinal paralysis.
8	R. L.	50, M.	Myoma uteri	Panhysterectomy	Shock.
9	L. C.	26, M.	Abdominal abscess	Abscess cavity opened and washed out	Tubercular peritonitis and meningitis.

EXPLORATORY (TABLE VIII.)

CASE 4.—Patient, on admission, complained of pain in lower abdomen, increasing in severity, also frequency of micturition accompanied by bearing-down pain and blood in the urine. There was some œdema of extremities. She had ceased menstruation for eight years. On examination, under an anæsthetic, the uterus was found to be very small and movable. To the right of it and slightly in front there was a hard irregular swelling about the size of a hen's egg adherent to the vaginal vault and probably extra-peritoneal. An irregularity could be felt in the posterior wall of the bladder, and the catheter came away full of almost pure blood. An exploratory ventral cœliotomy was performed, when it was found that uterus and appendages were atrophied. To the right side, and adherent to the wall of the pelvis, to the vaginal wall, and to other structures, a hard mass as large as a pigeon's egg was found. It was impossible to remove this, and the abdominal wound was closed with the intention of doing a vaginal operation later on, on the supposition that the hard mass was a calculus impacted in the ureter, which was considerably dilated above it. A colpotomy was performed twenty-one days later, but it was again found to be impossible to remove the mass and the patient was returned to bed. On discharge patient's bladder-symptoms were considerably improved.

DEATHS.

CASE 1.—This patient was operated on previous to Nov. 1st, 1896; but as her death occurred on Nov. 7th we have included her in our mortality table. A vaginal hysterectomy was attempted, but owing to a large number of adhesions it was not proceeded with, and the operation had to be completed by a ventral hysterectomy. Patient lost a considerable amount of blood, got uncontrollable diarrhœa in addition to bronchitis, and died ten days later. There was no peritonitis.

CASE 2.—With a history of three years' growth, the tumour reached almost to the ensiform cartilage, filling the pelvis and abdomen; it weighed 16 lbs. The patient had been suffering from menorrhagia for some months previous to operation, and her condition was low. The operation was not difficult, but the patient could not stand the shock, and died fifteen minutes after being put to bed.

CASE 3.—Complaining of menorrhagia and dysmenorrhœa, she was curetted on Jan. 25, 1897, and as a considerable quantity of thickened endometrium was brought away with the curette, iodine

was injected. The temperature commenced to rise on the next day, and reached 107.8°F. with a pulse of 130 on the fifth day. Notwithstanding uterine douching, and plugging with iodoform gauze, the patient died on the sixth day. *Post-mortem* showed no pathological change except in the spleen, which was large and hard, and contained a small infarct.

CASE 4.—For the past four months she had almost continuous hæmorrhage and severe pain; her uterus was myomatous, and both tubes enlarged. On opening the abdomen the pelvic contents were found universally adherent. Many of these adhesions were broken down, and both tubes and ovaries removed. Two days later patient commenced to vomit. Vomiting became incessant, the bowels could not be moved, and the abdomen became tympanitic. Intestinal obstruction was diagnosticated, and when the abdomen was re-opened a coil of intestine was found bound down by a band of adhesions causing complete obstruction; this was separated; she, however, did not recover.

CASE 5.—This patient was admitted to hospital with acute general peritonitis; temperature, 103.2°F. ; pulse, 120. There was an old prolapse of the uterus, with a sloughing ulcer on the cervix. The uterus was explored with a curette, and found empty. After consultation it was decided to open the abdomen and wash out the peritoneal cavity as a *dernier ressort*. In addition to general peritonitis the abdomen was full of fluid and lymph, which was washed out, the abdomen closed, and a drainage tube inserted. Patient died the same night.

CASE 6.—Tumour was the size of a full-time pregnancy, and before it could be removed from the abdomen twenty-two cysts were opened and evacuated. There were several adhesions binding the tumour posteriorly; there was a large cyst found adherent in Douglas' pouch, and this was opened and removed. The temperature commenced to rise immediately after the operation, but never exceeded 101.6°F. Pulmonary symptoms supervened; she was seen in consultation, and septic pneumonia was diagnosticated. She died on the eighth day.

CASE 7.—Myomatous uterus extending to umbilicus, and causing œdema of lower extremities and difficulty of micturition. Patient took the anæsthetic badly, in consequence of which there was considerable handling of intestines. On the fourth day she became very restless, and suffered from hiccough, but there was no vomiting; the bowels could not be moved. She died the next

day. Temperature and pulse normal. The *post-mortem* examination revealed nothing abnormal; the intestines were greatly distended with gas.

CASE 8.—Myomatous uterus extending almost to the ensiform cartilage, causing persistent and excessive hæmorrhage. She was extremely anæmic from the continuous loss of blood extending back for nearly twelve months, and had suffered from menorrhagia for the previous two years. The usual operative procedure for panhysterectomy was followed, but the loss of blood during the operation proving too much for her, she gradually collapsed, and died just at the conclusion of the operation.

CASE 9.—This patient was admitted with a temperature of 103·4° F., pulse 140, five weeks subsequent to confinement, with a history of "fever" and rigors from that time. The temperature continued high, and there was considerable abdominal swelling, from which the uterus was free. The swelling extended from above the pelvic brim to midway between the umbilicus and ensiform. On opening the abdomen a large quantity of foul-smelling pus escaped (about three pints); the intestines were adherent to the abdominal wall; and in making the incision a coil of the small intestine was opened and was stitched. The patient progressed favourably for a fortnight after the operation, the cavity continuing to discharge thin pus. The wound, except at the point of drainage, healed by first intention. At the end of this time she began to complain of persistent neuralgia in the head, with marked slowing of the pulse. The neuralgia would not yield to any treatment, the temperature began to rise, and the urine was highly albuminous. She continued to get worse, and four weeks after her operation the note recorded as to her condition is as follows:—"The patient has been in a semi-comatose condition for the last twenty-four hours, has ptosis of the right lid, strabismus, nystagmus and paralysis of the left side of her body, the bowels have not acted for several days, and the enemata administered have not been retained." She died the succeeding day. *Post-mortem* examination showed general tubercular peritonitis, with the abdominal contents matted together. On the right side the tube, which was much distended with pus and 7½ inches long, opened into an abscess cavity in the right lumbar region. The left tube, also distended with pus and of almost a similar length, was adherent to a coil of intestine in the pelvis, where it had ruptured, allowing a large quantity of thin pus to escape. Permission could not be obtained to open the cranium.

ART. VII.—*Operations for Strangulated Hernia.*^a By J. S. M^cARDLE, F.R.C.S.I.; Surgeon to St. Vincent's Hospital, Dublin.

(Continued from page 4.)

FEMORAL HERNIA.

IN carrying out operations for this hernia one has to be very careful of the tissues near the saphenous opening. I therefore make an incision from a finger's breadth below Poupart's ligament, extending upwards for three inches—there must not be undermining of the tissues below the incision—pass the index finger backwards until the resistance of Gimbernat's ligament begins; the edge of this band should be caught up with the nail. Then pass a blunt-ended hernia knife with cutting part directed inwards, pushing the knife against the edge of the ligament and using a sawing movement. All this time the left index finger holds back the bowel, and now this finger follows the knife to find that the ring is free. Open sac, examine contents, and should the bowel or omentum be dark in colour but still glossy, irrigate with warm saline solution until the circulation is restored; return into abdomen.

RADICAL CURE.

When the operation may be prolonged, so that the radical cure can be carried out, the incision should be a semilunar one, beginning above the middle of Poupart's ligament convex downwards, and ending a finger's breadth above the spine of the pubes; when the flap thus formed is turned up, as in Fig. 1, the femoral ring and canal are fully exposed, and plenty of room is obtained for necessary manipulations. The sac of the hernia is cut transversely an inch to an inch and a half below Poupart's ligament, and after complete reduction of the bowel or omentum, a long-bladed clip forceps is pushed through the external oblique from without inwards, and made to come through the femoral ring in front of the sac, the mouth of which it now grasps. Traction on this brings it through the oblique muscle, as at A Fig. 1, where it is fixed as shown. Now a suture, with a fully

^a A Clinical Lecture. Delivered at St. Vincent's Hospital.

curved needle at both ends, is passed deeply through the pectineus muscle, as at E E Fig. 1. The needles are now passed through the femoral canal, and made to pierce the

MR. M'ARDLE'S METHOD.

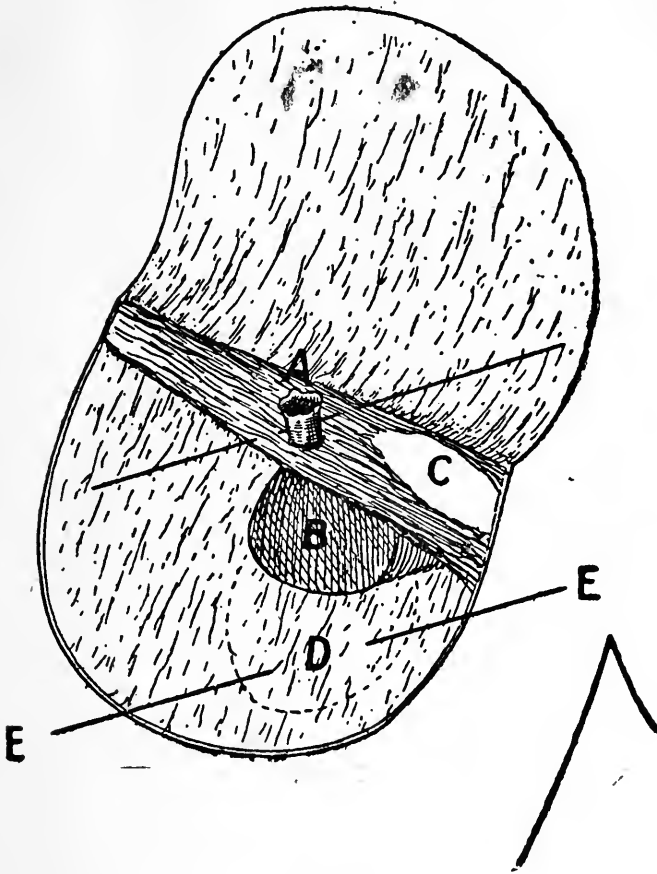


Fig. 1.

- A. Sac drawn through above Poupart's ligament.
- B. Neck of sac as first closing of femoral ring.
- C. External abdominal ring.
- D. Flap of pectineus destined to form second closing of femoral ring.
- E. Sutures to bring flap D into position.

external oblique, as at E E Fig. 2, no traction being made on the thread for the present. At this stage all bleeding points should be secured by ligature, and all forceps removed. Next, the pectineus muscle should be cut through, as shown by dotted line in Fig. 1, and the flap D drawn well inside the femoral ring to thoroughly block that opening, as shown

in Fig. 2. Replacement of the semilunar flap completes the procedure, silkworm-gut or silver wire being used to fix it in position.

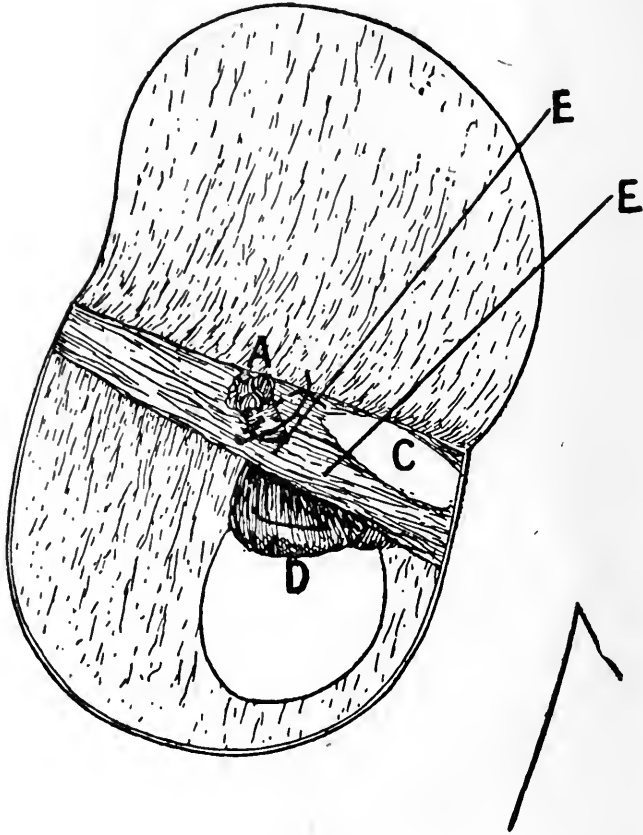


Fig. 2.

- A. Sac fixed by suture.
- B. Covered up by flap D.
- C. External abdominal ring.
- D. Piece of pectineus and pectineal fascia closing femoral ring.
- E E. Suture passed above Poupart's ligament holding pectineal flap in position.

It is only in cases of long standing, and where truss pressure has caused a general matting of the tissues, that there is any trouble in carrying out this procedure. Occasionally a very thin-walled sac gives way if drawn with force through the external oblique, but this accident does not seem to interfere with the course of the cases, as the pectineus soon becomes fixed in its new position, and closure of the femoral ring is complete.

It is advisable to keep the patient in the recumbent position for at least three weeks, and to insist on a measure of quietude for a month or six weeks afterwards. During all this time a broad, thick pad and a spica bandage should be worn.

Truss pressure is injurious since it causes absorption of the plastic exudate, which is so necessary to a firm closing of the hernial track.

It must be remembered that the healing of the skin wound must not be taken as evidence of repair of the deeper structures, and long after the external wound is secure the slightest exertion may undo all the plastic work in the deeper parts.

ART. VIII.—*Some Remarks on Typhoid Fever.*^a By HENRY C. DRURY, M.D., F.R.C.P.I.; Assistant Physician to Sir Patrick Dun's Hospital; Temporary Physician to Cork-street Fever Hospital.

It sometimes seems to me that we seek too much for out-of-the-way cases and rare conditions for the subject-matter of our discussions here, whereas the material lying at hand to everyone might prove more useful, not only to the person who made a thoughtful study of it, but also to the more general body of practitioners and patients. Consequently, though it may be said of typhoid fever as of other things, "There is nothing new under the sun," still it will be admitted there are many things to learn. Since the publication of Murchison's magnificent monograph on the Continued Fevers in 1862, little really new, and at the same time helpful, has been added to our knowledge of the subject, with the exception of the isolation of Eberth's bacillus in 1880.

"Widal's reaction," as a means of certain and scientific diagnosis, promised an important advance to our knowledge. The promise may yet be fulfilled, but it would be premature to say that it has been. No sufficiently exhaustive investigation, extending over a large number of cases

^a Read before the Section of Medicine of the Royal Academy of Medicine in Ireland, November 23, 1897.

of different diseases, and checked by autopsy—that wrecker of diagnoses—has yet been applied to the subject.

The most important communication on this question that I am aware of is that of Drs. Colville and Donnan, of Belfast, published in the *Brit. Med. Journal*, Oct. 16, 1897. They tabulate the results of the examination of 132 cases, by Widal's serum test for typhoid fever. The results are encouraging as far as they go, but the number is far too small from which to draw important and far-reaching conclusions. The cases which clinically ran a typhoid course numbered 105; of these 84 gave a complete reaction, 19 an incomplete reaction, and 2 no reaction at all. Only 27 clinically doubtful cases were tested, and of these only one gave the reaction, and it was a case of typhoid fever. In only one case was an autopsy performed, and it proved to be a case of general tuberculosis, but had not reacted to the test.

To make such an investigation of real use a much larger proportion of clinically doubtful cases should be examined. Let us suppose only four classes of cases to be examined—viz., typhoid fever itself, meningitis, tuberculosis, and ill-defined or simple fever. If the above 132 examinations were divided amongst these four it would only allow 33 for each—a number which, it will be allowed, is much too small, though the total of 132 represents no mean amount of time, work, and trouble.

Again, it is necessary that a large number of *post-mortem* examinations should be made of cases of all kinds that have been subjected to the test reaction. For this it would be necessary to make an autopsy in *every* case of death, and unfortunately our power to do this is so hampered by prejudice against such a real means of increasing our knowledge, that I fear it must be left to some less free country than ours to carry out the investigation.

Drs. Colville and Donnan say, “Surely a method which has proved in this instance to be correct in over 98 per cent. of cases, must undoubtedly have a very solid foundation.” I say it is that very 2 per cent. we are anxious about. With dogged Northern perseverance, which we all admire, the splendid buildings of Belfast have been

reared on 30-foot piles driven into the mud. Would those foundations be described as "very solid" if 2 per cent. of the piles were omitted—especially if it was at the corners that the omission occurred? It is the "corners" we want to be sure about in our diagnoses. Practising physicians, to make use of the test, will only want it in doubtful cases, and after it is made it will not do to ask ourselves, "Is this one of the 2 per cent.?"

I do not wish to disparage in the least what has been done, what I would be proud to have done myself, but I can consider it only a step. Unless an enthusiast, independent of his profession, turns up we can do little under present circumstances. Consider what would be required. It would be necessary, in order to get sufficient cases, that he should have the run of every hospital in Dublin, and therefore the co-operation of every physician connected therewith; that every tested case which died should have the cause of death verified by *post-mortem* examination; and, in addition to all this, a well-equipped laboratory and unlimited time at his disposal.

In the *British Medical Journal Epitomé*, Nov. 13, 1897, there is notice of an important article by Widal and Sicard reviewing the state of our knowledge on this subject, and their own conclusions based on the study of 163 cases. The conclusions are, on the whole, good.

The latest novelty has been in the line of treatment, as it not infrequently is. But in this instance the novelty opens up a wide field for research and experiment which may carry us many steps in advance of anything before. I refer to the antitoxin or serum treatment. It may be that here we have touched the penumbra of that shadow which will eclipse all other forms of treatment, not only in this but in many other varieties of disease. I believe we have not only touched it, but have already entered it. As yet, however, it is too hazy to make any calculations from it; but I believe we are on the eve of such discoveries in the treatment of specific diseases as will do much to remove the stigma that rests upon our profession—that in most cases our function is to watch the uncontrolled course of disease, endeavour to prevent complications, and treat

them when they arise. Though this change will not come upon us with the swift surprise that Listerism came upon the surgical world, it will be looked back to by future generations as an epoch in medicine, just as Lister's enunciations mark an epoch in surgery. All honour to the great crowd of workers in this grand field of research, but in the number of men, the number of names applied to the method, and the number of years it is taking to thoroughly unravel the intricacies of the subject, it seems to me the tendency is to forget the master mind who first conceived that the tangled skein had an end, and quietly and diligently sought for it until he found it, hidden though it was in ignorance, prejudice, and doubt. As Prof. Richet said at the last meeting of the British Medical Association, serum therapeutics are "a direct consequence of the labours of Pasteur."^a What more suitable title for the method that he inaugurated could be applied to it than one derived from that great name?

As yet the serum treatment of typhoid fever has been but little tested. That universal provider for all bountiful prescribers, the firm of Burroughs, Wellcome & Co., has, with praiseworthy business promptitude, supplied an anti-typhoid serum. Of course we know nothing about its mode of preparation. Some seven cases have been reported in the *British Medical Journal*^b up to the end of 1897, in which anti-typhoid serum was used; that supplied by the above-named firm was the preparation used in all. In all the cases there appeared to be marked improvement, and finally, recovery after its use.

If this line of treatment should, in the future, yield such results as to demand its universal practice, it will be another bright jewel in the diadem of science.

Science cannot stand still, and amongst her workers our countryman, Prof. A. R. Wright, is working hard at the setting for another and brighter jewel, since prevention is better than cure.

^a British Medical Journal, Sept. 18, 1897.

^b British Medical Journal.—Jan. 30, 1897, p. 259, 4 cases, Dr. Pope; Feb. 27, 1897, p. 518, 1 case, Dr. Cooper; April 17, 1897, p. 970, 1 case, Dr. Steele; July 10, 1897, p. 81, 1 case, Dr. Howlett.

In the *Lancet* of Sept. 19, 1896, he described in detail a method for the preparation of a substance for vaccination against typhoid fever. He was the first to introduce it and the first to practise it.^a He has been working at it earnestly since, and quite lately vaccinated a batch of men at Netley who were going to India,^b where typhoid fever is rife and where it claims a fatal power over the larger number of its European victims.

These are the newer lines in which science is now leading us. We, as practising physicians, must wait till the tools are fashioned to our hands by the workers in the laboratory. There is no reason, however, why we should not endeavour to help, and it seems to me that those who hold important positions in our public hospitals might, without any great outlay of time or money, help greatly by systematically experimenting, observing, tabulating, and then reporting results.

Thinking back on the older methods, there are very many subjects, any one of which might be made the subject-matter of an instructive discussion here. I will refer in the most general manner to two or three, avoiding particulars as far as possible.

It often happens that when certain lines of treatment are introduced or advocated by leading men, these lines are taken up by all or sundry as hobbies, and ridden to death. Thus with the depressant treatment of old; it went to such extremes that doubtless many were bled, starved, or depressed to death. Naturally with the introduction of the nutritive and stimulant treatment, the pendulum swung off to the opposite extreme, and many victims gave up the struggle for life, gorged or intoxicated. Then the stand-off treatment "took on," and men thought with awe of the ulcerated bowel seen at the last pathological gathering. They looked upon the mildest purgative as the deadliest poison.

Then master minds pointed out the value of removing undigested and putrefying material from the bowel by a dose of calomel. This was found harmless, so "Eureka!" calomel became the fashion, and was to disinfect the whole

^a Vide *British Medical Journal*, Jan. 30, 1897.

^b *British Medical Journal*, Oct. 9, 1897.

gastro-intestinal tract, and so cure typhoid like a charm. Thus the hobby romped as before.

Every one of these began well, contained germs of truth and good treatment, but when taken up by unthinking minds became mere hobbies, and so their grotesqueness laughed them out of court—carrying the good with them.

For example—the pendulum has swung back again to-day with many, and they dread, and so avoid anything in the nature of a purgative in typhoid fever. Murchison was not so timid. He says :—“ It does not follow, however, that no interference is justifiable when the bowels are constipated. When there is constipation at the commencement of the attack it is well to commence the treatment by a small dose of castor oil, or of rhubarb in peppermint water. When the bowels are confined at a later stage I am in the habit of prescribing every second or third day one or two teaspoonfuls of castor oil, or a simple enema.”

This I believe to be sound practice, though not common practice. It is, however, followed out at Cork-street Hospital at the present time. There, unless the evacuations are moderate in amount, and of normal typhoid appearance, the patient is given the day after admission 1 or 2 drachms of castor oil, or 2 grs. of calomel. Either in this small dose acts quietly, but efficiently; the dejecta are further examined, and if solid matter or undigested curd, &c., are still passed the dose is repeated. Constipation also is treated in a similar manner, allowing only one day to elapse without a motion. Thus, at any stage of the disease 3i of castor oil, or 2 grs. of calomel are given if indicated, without fearing any ill effect whatever, whether of hæmorrhage, perforation, or diarrhoea. There is no routine in this, judgment is used in each case, and in each act of prescribing. It is routine that kills many a good practice.

Another important consideration is—the time to commence solid food. I know from experience that very various ideas are held on this subject, indeed some people seem to have no ideas on it at all, or at least follow no rule or course of practice in connection with it. Murchison is very vague on the question. He says, “ Diet must be at

first restricted to such articles as milk, eggs, farinacea, custards, light puddings, beef-tea, chicken tea, calves'-foot jelly. Meat must not be allowed for at least seven days after the cessation of pyrexia." Therefore, sometime within the first seven days of apyrexia he allowed eggs and farinacea.

In Cork-street, where there is a great field for observation, and where the experience of years has been condensed, the patients are given a very small quantity of solid food—viz., bread-crumb or plain arrowroot biscuit about the third or fourth day of apyrexia. The temperature is carefully watched, and if there is any rise that evening, or the next morning, the food is discontinued, and a dose of oil or calomel is given immediately. In nine cases out of ten the temperature falls that evening or the following morning, and after two or three more days food is again given without bad result. It is very seldom that a rise of temperature occurs after food given on the third or fourth day. As a general rule the amount of solids given is gradually increased daily. Anything of the nature of a true relapse is extremely rare. I really believe this to be due to the prompt clearing out of the bowel on the first appearance of a rise of temperature. I may be criticised for appearing to lay so much stress on a rise of temperature. Of the number of degrees it rises I pay but little heed; I look on it only as an indication—the earliest and most delicate, I believe—that something is wrong, and we must be "on guard."

On one occasion a patient who had very severe illness was surreptitiously given by another patient a large slice of bread and butter. That night the temperature ran up to 104°; in the morning the culprit confessed. A dose of oil was given, repeated each morning, and by the third or fourth day the temperature was normal, and remained so. I could multiply such cases. We cannot lay down hard and fast rules on this subject. I have seen food given on the second day of apyrexia without bad effect, and again have seen a regular relapse follow the first ingestion of solid food on the seventh day. Indeed, who has not seen a relapse where solid food had not been taken at all?

In private practice I think it better to be on the safer side, and leave the larger interval between fever and food. Here everything is so anxiously watched and discussed by over-anxious friends that any elevation of temperature or stopping of food once given creates such a scare that great harm is done and great blame incurred. But in hospital practice we have a freer hand—time is precious; the difference between three and seven or ten days' abstinence from solid food is a great one for the yearning patient, and is great too in speeding or retarding the restoration of strength; the bed is needed for another patient; the patient is sorely needed back to his or her family—and every day we can gain is thus important. I can well understand diversity of opinion on this point. I lay down no law, I advise no routine short cut to convalescence; but I say we must be guided by circumstances and by individuals. I have heard years ago the hard and fast rule laid down, "Never give solid food till the tenth day of apyrexia." In some cases this may be necessary, but in many cases it would amount to unnecessary cruelty.

The last subject to which I will refer is the somewhat strange one of the use of the bed-pan. It seems to be almost an article of faith that as soon as a patient is pronounced in typhoid fever he must use a bed-pan for the rest of his illness. All Murchison says about it is this, he refers you back to typhus fever, and there says—"After the first week in severe cases they ought to be provided with a bed-pan, and on no account to get out of bed." This comes into a section commencing—"Steps must be taken to prevent the patient exhausting his muscular and nervous power." I presume, therefore, that is the object of the bed-pan in typhus, but he makes no mention of it in enteric, therefore it is not clear whether he recommended its use to preserve muscular and nervous power, or to guard against the danger of perforation or hæmorrhage—probably he had all these objects in view.

There is no doubt that to many people the use of the bed-pan is exceedingly irksome. I believe that to nearly everyone it is so at first. Some find the greatest difficulty in making use of it, and except in the case of "needs must"

cannot or will not do so. I remember one doctor that I attended who, though he had not enteric, had diarrhœa and such extreme weakness that we feared his sitting up. We tried by every art and persuasion to get him to use the bed-pan, he did try a few times, but, after that, persuasion was useless; he would always get out of bed to the night-chair as long as he had strength to do so.

A doctor who was ill with fever in Cork-street Hospital had a similar experience, and so hated and dreaded the trials he made to use the bed-pan that he raved about it when he became delirious, and always insisted on getting up to the night-chair.

It will surprise many here to learn that the bed-pan is seldom used, even in typhoid fever, in Cork-street Hospital. There is a night-chair beside every bed, and as long as the patient is able to get up to this he is allowed to do so. The nurse gives him assistance and covers him up. Only when unable to get out of bed is the bed-pan used; then it is found in many cases to be unnecessary, as by that time the patient generally passes all evacuations unconsciously.

The arguments in favour of the unusual practice are:—

1. Less annoyance to the patient.
2. More complete evacuation of the bowel, and therefore less frequent disturbance.
3. The more natural position causes less straining, and therefore really less risk of either hæmorrhage or perforation.

A weak patient cannot fall off the chair on account of the strong high arms, which give him comfortable support while he sits.

It will, of course, be objected that this is a ready way of courting disaster, either by hæmorrhage, perforation, or syncope. I can only say that we do not find it to be so.

I have looked up the bed cards of all cases admitted during a period of five months. During that time 92 cases were treated, 9 of whom died. Of the 83 that recovered not one had either hæmorrhage or perforation. Of those who died:—

No. I. was ill 20 days before admission; had hæmorrhage the day after admission; died 15 days after.

No. II. was ill 8 days before admission; developed double pneumonia; died 9 days after admission.

- No. III. ill 14 days before admission; died within 26 hours with double pneumonia.
- No. IV. ill 9 days before admission; died 10 days after, due to general severity of disease without special complication.
- No. V. ill 8 days before admission; died 4 weeks after; had constant high temperature with pulmonary complications.
- No. VI. ill 7 days before admission; died 3 weeks after; had very high temperature, insomnia, pulmonary complications, gradual cardiac failure.
- No. VII. six days ill, at least, before admission; died 10 days after from pulmonary complications and gradual cardiac failure.
- No. VIII. one month ill before admission; died 6 days after from gradual cardiac failure.
- No. IX. ten days ill before admission; died 11 days after, having profuse diarrhœa and pulmonary complications.

I would apologise for giving the particulars of only five months' cases. They were consecutive months, not specially selected. As I had to search through all the bed cards for these particulars, and as the daily average number of cases in the house was about 180, it was no small labour going through all the cards of five months, it being remembered also that Cork-street is not a very convenient place to get at for a spare hour. I hope, therefore, that you will accept the examination of these 92 cases as bearing out what I say—that hæmorrhage, perforation, and syncope are very rare complications with us.

In further support of the general treatment of typhoid at Cork-street Hospital I would mention that at the London Fever Hospital from 1848–1870 the mortality was 17·26 per cent. From 1871 to 1882, after the exclusion of pauper patients, the death-rate was 15·9 per cent.; at Cork-street Hospital, from 1871 to 1890, the death-rate was 8·6 per cent., only half the mortality of the London Fever Hospital.*

In 1894 - 260 admitted with 20 deaths.

„ 1895	- 105	„	9	„
„ 1896	- 106	„	8	„
„ 1897	- 260	„	29	„

* Dr. J. W. Moore. Eruptive and Continued Fevers.

So that the mortality with us still remains low.

There is no wish to dogmatise as to the best methods or results, but simply the desire to have them discussed by those with more wisdom and greater experience. I claim nothing in the least original in the foregoing remarks; they give simply the result of experience gained by observation of the methods and results of an institution with a very honourable record; but I would pay a tribute to the real head of that institution, Dr. J. Marshall Day, the Resident Physician, who makes that record honourable. Nor have his fourteen years of service begotten one suspicion of routine to dull the edge of his zeal, observation, industry and care, which have made Cork-street Hospital a favourite resort of our Dublin poor in their bitter hour of sickness.

ART. IX.—*Dissecting Aneurysm*.^a By JAMES B. COLEMAN, M.D., Royal Univ. Irel.; M.R.C.P.I.; Physician to the Richmond, Whitworth, and Hardwicke Hospitals, to the National Hospital for Consumption for Ireland, and to the Children's Hospital, Dublin.

THE term "dissecting aneurysm" is applied to cases in which a partial rupture of the inner tunics of an artery allows the blood to become diffused between the coats of the vessel. Having regard to the difference of opinion which exists as to the author of the original description of this very remarkable affection, the following extract from Dr. Peacock's "Report on Cases of Dissecting Aneurysm"¹ may be of interest:—"It has generally been supposed that Laennec was the first writer who applied the term 'dissecting' to this form of aneurysm, but it has been recently shown by M. Broca that M. Maunoir employed the same designation, and clearly described the formation of aneurysms of this kind in his work published in 1802. A characteristic case is also related by Mr. Allan Burns in his work on 'Diseases of the Heart and Aneurysm,' published in 1809."

Shekelton² published two cases of dissecting aneurysm in 1822, and the preparations are to be seen in the Museum of

^a Read in the Section of Medicine of the Royal Academy of Medicine in Ireland, May 20, 1898.

the Royal College of Surgeons in Ireland. Erichsen, in the earlier editions of his "Science and Art of Surgery," incorrectly refers to this variety of aneurysm as "originally described by Shekelton," and the use of the name "Shekelton's aneurysm" as a synonym for dissecting aneurysm is not justifiable.

Dr. Peacock, in the paper to which I have already referred, collected 80 instances in which the affection appeared in well-marked form, including five cases published by Shekelton,² R. W. Smith,³ Kirkpatrick,⁴ Lees,⁵ and MacDonnell⁶ respectively, in the *Dublin Journal*. An interesting specimen was exhibited by Dr. Conolly Norman at the Pathological Section of the Academy a few months ago.

In the earlier published cases of dissecting aneurysm it was supposed that the separation of the coats of the artery took place between the middle and external tunic; but modern pathologists agree that the blood almost invariably makes its way between the laminæ of the middle coat, so that the outer wall of the aneurysm is formed of the outer strata of the media together with the adventitia.

In the vast majority of cases the rupture of the inner tunics is due to their excessive lacerability—the result of atheromatous degeneration. Indeed, out of 60 of Peacock's cases the arteries were found healthy in only two instances. Von Ziegler⁷ suggests that in the rare absence of morbid changes in the coats of the vessels, traumatic injury to, or defective development of, the vessel wall is the primary cause of the lesion, and Walshe⁸ mentions two cases in which dissection of the aortic coats on a limited scale had been abruptly effected as the result of railway concussion. On the other hand Rokitansky⁹ supposes that in some cases a morbid condition of the external coat deprives the inner coats of support, and so predisposes to their rupture.

Dissecting aneurysm is practically confined to the aorta and its large branches, although von Ziegler⁷ states—on what authority I do not know—that the small arteries of the brain are a usual seat of the affection.

The internal rupture is usually situated at the origin of the aorta, or in the ascending aorta—it was so in 55 out of 73 of Peacock's cases—but it has been found as low as the

end of the abdominal aorta, as happened in Shekelton's cases. The direction of the internal rupture is generally transverse when it is near the aortic valves, whilst it is more frequently vertical at the beginning of the descending aorta.

Ordinarily the arterial coats are torn asunder over one-half to two-thirds of the circumference of the aorta, although the separation of the tunics occasionally extends completely around the vessel. The longitudinal extent of the separation of the tunics varies considerably; as a rule the aneurysm is limited to the ascending aorta, but it is occasionally found to extend beyond the iliac arteries. In my case the separation of the coats begins at the arch and ends in the left femoral, and in a very remarkable case recorded by Tessier¹⁰ the separation extended from the commencement of the ascending aorta to the left popliteal artery.

The dissection not infrequently is carried along the primary branches of the aorta; for instance, in MacDonnell's and Tessier's cases it extended through the innominate artery and its branches to the internal carotid; in another case¹¹ it followed the course of the coronary arteries; in Laennec's case¹² it passed along the coeliac artery, and in my case into the right renal artery.

Some of the intercostal and lumbar arteries are frequently found to be cut across by the stream of blood, "so that a probe introduced into the aortic orifice of one of those little branches passes directly into the aneurysmal canal, and traverses this before entering the artery itself, which thus appears to arise directly from the aneurysm."¹³

In cases which have ended fatally within a short time, there has been only a single opening leading from the aorta into the arterial coats, death having been usually due to the subsequent giving way of the external wall of the sac. This is the common form, comprising 73 out of Peacock's 80 cases; my case is also an instance of it. On the other hand, when life is prolonged for any considerable time, the blood is found to have forced its way from the sub-adventitious sac back again to the blood-stream at some point farther on in the course of the vessel. In such chronic cases—of which Shekelton's and Hilton-Fagge's

cases were examples, the new blood-channel acquires an endothelial lining.

The disease is specially common in persons of advanced age, and though it probably occurs more frequently in men than in women, there is not the excessive preponderance in males which is the rule in ordinary aneurysms. Indeed some writers say that it is more common in women.

The case which I now relate, and the specimen which I exhibit, typically exemplify the symptoms and pathology of the early stage of the fully-formed dissecting aneurysm.

CASE.—A man, sixty-five years of age, a house-painter by occupation, was admitted to the Whitworth Hospital under my care on 13th Jan., 1898, complaining of severe pain in his back and of loss of power in his legs. On the morning of his admission to hospital he was on a ladder engaged in papering a room when he was suddenly seized with a violent pain in the lower part of his back and in his left hip. The pain appeared to start from his lumbar region and to shoot up into his chest and down to his left thigh. It was so intense that (to use his own expression) he “bellowed with agony.” He felt faint, but did not lose consciousness, and he was able to walk across the room with difficulty to a chair. Within a quarter of an hour his lower extremities were completely paralysed, and his left leg was anæsthetic. He was removed to hospital in a few hours. Beyond the fact that he was a painter, there was nothing noteworthy in his personal history, and he came of a healthy family. On admission to hospital he was a well-nourished, grey-haired old man, rather anæmic. He was unable to walk, but he could move his legs slightly. He still suffered from severe pain in his back, but he had already recovered sensation in his left leg. Everything he ate or drank was vomited. His arteries, in which there was visible pulsation, were atheromatous, and his pulse high tensioned. Heart was hypertrophied; no murmurs could be detected, but aortic second sound was accentuated. He was carefully examined for aneurysm, with a negative result. Pulsation could be felt in both of his femoral arteries. There was marked *arcus senilis*, and his gums showed a “lead line.” His urine was feebly alkaline, sp. gr. 1014, clear, contained .2 per cent. albumen, and a few hyaline and granular casts; neither sugar nor blood was present; the quantity of urine passed was about the average amount. He had control

over the sphincters of bladder and rectum. Knee-jerks and plantar reflexes were lost.

The pain in his back ceased after twelve hours, and next day he felt much better, and he was able to move his legs freely. On the following morning he was able to walk a few steps, and he expressed himself as feeling almost quite well. At this period I showed him to the hospital class, and I diagnosticated the case as plumbism and chronic interstitial nephritis, with the usual cardio-vascular changes. I pointed out that the history of the attack clearly indicated some vascular lesion of the spinal cord, and the sudden onset, wide diffusion, and intensity of the pain, together with the transient duration of the paraplegia, appeared to justify the further diagnosis of spinal meningeal hæmorrhage. The patient was apparently well about four o'clock in the afternoon, when he took a drink of milk. Five minutes afterwards the nurse found him dead in his bed. His death occurred about fifty-two hours subsequent to the onset of the symptoms.

The *post-mortem* examination, which was made within twenty-four hours of his death, showed the right pleural cavity to be filled with blood. The pericardium contained a little clear serous fluid. The heart was rather large, there being hypertrophy of the left ventricle. The arch and upper part of the descending aorta were distended and formed a tumour-like mass, from which the blood had escaped into the right pleura. On opening the aorta its inner aspect was covered with atheromatous plaques, and a dissecting aneurysm extended from the arch, at the level of the innominate artery, and terminated in the left femoral artery about an inch below Poupart's ligament. A large mass of freshly-coagulated blood was effused between the tunics at the level of the arch and in the upper portion of the descending thoracic aorta, and here the separation of the tunics took place around nearly the whole circumference of the vessel wall. From the abdominal aorta through the left common iliac, external iliac, and femoral artery the coats of the vessels were separated by a thin layer of coagulum, but no palpable thickening of the arteries was so produced. In the lower part of the aneurysm the dissection of the arterial coats did not extend much more than halfway around the circumference of the vessels.

The microscopic sections, which I exhibit, are from the left common iliac artery, and they show that the blood is effused in the substance of the middle tunic of the artery, so that the

external wall of the aneurysmal canal is composed of the outer muscular strata of the media together with the adventitia. The dissection was carried along the coats of the right renal artery, the lumen of which was also occluded by a thrombus. The lumbar arteries were cut across, and their orifices likewise contained thrombi. A large coagulum was adherent to the posterior wall of the aorta at the level of the renal and lumbar arteries.

The external rupture of the aneurysm was situated about the middle of the thoracic aorta on its posterior aspect. The rupture was an ill-defined, oblique slit, about half an inch long, from which the blood had forced its way through the connective tissue into the right pleura.

I have not been able to satisfy myself as to the position of internal rupture. It might have occurred two or three inches from the termination of the abdominal aorta, for the atheromatous changes were most intense in that position, or possibly it took place at the origin of one of the primary branches of the aorta.

Both kidneys were cirrhotic, the right one being, in addition, cystic and extremely engorged with blood. Microscopic sections of this kidney (prepared by Dr. Dargan in Dr. McWeeney's laboratory) show that it is in a condition of universal hæmorrhagic infarction. There was no hæmorrhage in the spinal cord or its membranes.

In the light of the autopsy it is not difficult to account for the symptoms of this case. As predisposing causes of dissecting aneurysm my patient had extensive atheroma of the inner coats of his aorta, which were consequently unduly lacerable, and, in addition, he had hypertrophy of the left ventricle with high arterial tension. The intense pain at onset of the symptoms was due to the primary rupture and separation of the coats of the aorta by the blood; the paraplegia was caused by the interference with the arterial supply to the lumbar enlargement of the cord, partly from thrombosis, partly from rupture of the lumbar arteries; the sudden death ensued on the rupture of the external wall of the aneurysm and the consequent escape of blood into the right pleura. It is rather remarkable that his urine contained no blood, and that the amount passed was not noticeably diminished, for the right kidney was engorged with blood, and its secretion must have been completely arrested.

Other cases of dissecting aneurysm have been recorded in which a remarkable series of symptoms was due to arrest of vascular supply to the brain, kidneys, or cord.

Tessier's¹⁰ patient died with the symptoms of apoplexy, and a dissecting aneurysm was found extending from the arch of the aorta along the innominate artery and its branches to the internal carotid.

Todd's case¹⁴ was characterised by hemiplegia and transient suppression of urine, and the *post-mortem* examination showed softening of the brain due to obstruction in the carotids, and it is probable that there was also obstruction in the renal arteries.

Sainet¹⁵ records a case in which the patient became rapidly paraplegic.

Latham and Swaine's¹⁶ case was diagnosticated during life. The patient was suddenly seized with "agonizing" pain in his chest followed by paraplegia.

In Dickenson's¹⁷ case a policeman, after seven hours on his beat, was seized with loss of power over his lower extremities, followed by pain and collapse. Death took place within 24 hours.

Where the symptoms are liable to such variation, it is evident that the diagnosis of dissecting aneurysm must always be difficult and uncertain.

In reference to treatment, Walshe⁸ somewhat cynically remarks, "Were the practitioner fortunate enough to divine the occurrence of acute separation of the coats of the aorta, it does not appear that in the present state of our knowledge the management of the case would be materially improved by his sagacity. Did he fail to diagnose the occurrence, his aim would be to restore the patient from the first shock of the accident, control excited arterial action, and relieve symptoms as they arose. And it does not appear that art could do more than this were the anatomical nature of the affection understood from the first."

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A CHARMED LIFE.

DR. CRAWFORD (*Indian Medical Gazette*), in his article on gunshot wounds, reports the following case:—Sepoy Jagat Singh, 31st Punjab Infantry; age, thirty-five; service, eleven years. Wounded at Agrah on the 30th September [1897], and admitted here on the 19th October. Seven bullets entered at the outer side of the back of the right thigh and, travelling horizontally, came out on the inner side of the back of the thigh, causing a simple flesh wound. On admission here the track of the bullet was healed. He was discharged on the 19th November, and sent on two months' sick leave.

THE CONGENITALLY BLIND AS OUTLOOK-MEN AT SEA.

THE frightful catastrophe of the sinking of the SS. *Bourgogne* reminds us of a lecture delivered some years ago by Dr. Dufour of Lausanne. This celebrated oculist, interested in the means of securing a livelihood for the unfortunate blind, passed in review all the callings which might make use of the extraordinary power of hearing with which these persons are endowed. Among others, he declared that all swift vessels should have on board two men born blind to serve as outlook-men in foggy weather. Dr. Dufour declares, as a result of experiments made on the Lake of Geneva, that the acuteness of hearing in these persons is such that they can easily recognise at a great distance the noise of a moving vessel, and *a fortiori* the acoustic signals which it may make with the object of furnishing exact information as to its position and course. The suggestion is a valuable and a practical one.—*Lyon Medical*, July, 17, 1898.

PART II.

REVIEWS AND BIBLIOGRAPHICAL NOTICES.

William Stokes; His Life and Work (1804–1878). By his Son, WILLIAM STOKES, Surgeon-in-Ordinary to the Queen in Ireland. London: T. Fisher Unwin. 1898.

IN the opening sentence of the preface to this biography, the writer "being to a great extent at a disadvantage, as a son must always be who attempts a biography of his father," appeals to the indulgence of the reader to enable him to look with a tolerant eye on the pages of the work before him. We can answer for at least one reader, who regards the modest but appreciative thoroughness with which he has carried out his peculiarly difficult task, as one of the most striking pieces of evidence that could well be produced of the tastes and aspirations in which he must have lived and moved while under the guidance of his noble and highly-gifted father. Could the spirit of William Stokes be permitted to look down upon the scenes of his former earthly exertions, we venture to say that one of its keenest gratifications would consist in observing the continued maintenance of the lofty standard of artistic, moral, and social tastes which must necessarily constitute the highest tribute to the educational methods adopted in the paternal home at Merrion-square, N., Dublin.

Heroes of all types are very much be-written in this extremely practical, scientific, money-making, but, alas! deplorably *un-heroic* age. The great warriors who committed most murders, the great statesmen who most successfully swindled all rival nations, the great educators who most skilfully fettered and tortured the youthful intellect, the founders of the great religions who manufactured the largest lies with the most natural ease and vigour, have all been recently receiving their due share of attention and applause. The "Masters of Medicine" are

now honoured with a few grains of appreciation, and the leading representatives of the one profession which was practised and blessed by the Saviour of mankind are permitted to follow in the train of the greatest spoilers of their species. The name of William Stokes adorns the title-page of the fourth of the very tastefully-produced volumes of this series; which, like its predecessors, does credit to the taste of the eminent publisher, T. Fisher Unwin, and, we may add, to the skill of his printer and of his bookbinder. This volume includes 256 pages, and is embellished by three illustrations—a frontispiece of the statue by Foley, a reproduction of Sir Frederick Burton's drawing of Dr. Stokes, and one of St. Fintan's churchyard, where rest the earthly remains of the subject of this memoir. The latter bears the inscription, *Margaret Stokes Pinx't*—a contribution of the accomplished daughter of William Stokes to the memory of her honoured father. The text is divided into thirteen chapters. There is an appendix which contains a bibliography of Dr. Stokes's writings, and a letter written from St. Louis, Mo., by Thomas O'Reilly, M.D.—formerly one of his pupils at the Meath Hospital. This document refers to the death of the erratic Irish genius, Clarence Mangan; the closing hours of whose unhappy life were soothed by the benevolent care of Dr. Stokes.

“William Stokes, the subject of the present memoir, belonged to a family members of which have for five generations occupied more or less prominent positions in the public life of Ireland.” It is interesting to note at this date that Gabriel Stokes, the founder of the Irish family of this name, who was an engineer by profession and lived in Dublin from 1680 to 1721, published “A Scheme for effectually supplying every part of the City of Dublin with pipe-water.” The high reputation which this gentleman made in his adopted country has been well and truly maintained by his descendants during the past two centuries, throughout the entire period of which they have been prominent representatives of the progress of Science, Literature, and Art, both in Ireland and in Great Britain. Whitley Stokes, the father of the “Master of Medicine” with whose

“Life and Work” we are now immediately concerned, was, in the early years of this century, a Senior Fellow of the University of Dublin, a Professor of Medicine in the Royal College of Surgeons in Ireland, a conscientious nonconformist in religion—for which he suffered the loss of his Fellowship in the University, and a true Irish patriot, who loved his country too well to wish to soil the pages of her annals with a further record of bloodshed. “What he would highly, that would he holily,” was the spontaneous tribute paid to his moral worth by Theobald Wolfe Tone, who testifies in a letter to a friend—“I look upon Whitley Stokes as the very best man I have ever known.” We think it desirable to mention these facts and observations in order to give our readers some idea of the exceptionally inspiring influences under which the early years of William Stokes’s life were spent.

The boyish years of the future apostle of medicine were distinguished by his love for poetry and romance, and by his apathetic indifference to distinction in the usual school exercises, and to the athletic games and field sports by which the large majority always prefer to cultivate the muscular system, of whose availability they are sure, to the neglect of the intellectual, whose existence is so often visionary. The love of Walter Scott and of the romances which he collected and which he originated, began almost with the beginning, and ended only with the end, of the active life of William Stokes. Human nature always hankers most after what cannot be reached, and the history of Stokes’s own life and works forms the most instructive comment on the want of that “University training” which he regretted all through life. No Jewish University conveyed to King Solomon his all-comprehending knowledge, nor did a corresponding Greek establishment give to Aristotle the attainments by which he gained a two-thousand-years’ lease of the intellectual monarchy of the world. Is there any evidence that William Shakespeare ever even *once saw* the inside of a University? How much had “University training” to do with the authorship of what are probably the most enduring prose works of our language—“*The Pilgrim’s Progress*” and “*Robinson Crusoe*”? The only

prominent fact which history has recorded of the University life of Francis Bacon was that its experience gave him a rooted dislike to the philosophical teaching of his time, which it became the labour of his life to overturn. The greatest metaphysical work of the English language bears on its title-page the honoured name of John Locke, *Gent.*, not John Locke, M.A., although the author was a University graduate. The want of an Oxford degree—where his fourteen months of residence are described by himself as “the most idle and unprofitable of my whole life”—did not in any way prevent Edward Gibbon from rearing the most magnificently monumental landmark which the literature of history can show. And although Charles Darwin had the advantages of a University course, it most certainly was not by working along the lines of its “training” that he succeeded in formulating the theory by which he was able to thunderstrike all the educational institutions of his generation, from his own Alma Mater down to the smallest village school. And the want of a “University training” did not prevent William Stokes from becoming the *ὁ ἐκείνος* of Medicine in his day; an ideal ambition at least quite as successfully gratified as was the famous visionary choice of the Greek philosopher.

The fact that chemistry appears to have been the first of the physical sciences to attract the youthful attention of William Stokes is significant testimony to the existence of the faculty of observation and the curiosity to pry into the secrets of nature—both of which are brought so prominently into action by this science.

In Edinburgh, where he went to prosecute his medical studies, he was “stimulated by the magnetic influence of Professor Alison”—an influence which appears to have lasted through life; and the interesting anecdote (pp. 31–2) in which we are told how the unknown student volunteered to accompany the poor and helpless fever patient to his home, is happily illustrative of the sympathy and devotion to his professional work with which the young Stokes was even then inspired.

A phenomenal fact in the history of our student is that when the stethoscope was new, and—the old, old story—a

good deal sneered at by the successful senior members of the profession, William Stokes, then aged twenty-one, published in Edinburgh a small treatise on the use of the instrument whose invention absolutely revolutionised the diagnosis of thoracic disease. The medical student Stokes became the apostle of the stethoscope to the English-speaking world! This small slip from the growing tree of knowledge waxed great; and blossomed in after years into the clinical classics—"Diagnosis and Treatment of Diseases of the Chest" and "Diseases of the Heart and Aorta," in which the gifted author was able to supplement and expand the observations of the inspired inventor of the stethoscope, supply many of his omissions, correct inevitable mistakes, and furnish the best possible commentary on his own remark on the use of this instrument, that it was "not as was formerly supposed, a means of forming a useless diagnosis in incurable disease, but one in which the ear is converted into the eye."

In this same year (1825) Stokes obtained his degree in Edinburgh, returned to Dublin, and received the appointment of Physician to the Dublin General Dispensary. In the following year he was chosen Physician to the Meath Hospital; which, accordingly, from this date formed the central arena of his professional work. Here William Stokes was exceptionally fortunate in having for his colleague Robert James Graves, in association with whom was initiated and carried into practice "a system of clinical instruction till then unknown in this country, which eventually acquired a world-wide fame for the Dublin School of Medicine." The author of the memoir before us tells his readers how the success of those gifted and enthusiastic teachers of medicine was so great that "crowds of students not only from other British Schools, but also from the Continent and America, attended the Meath Hospital clinique." From the surviving reputation of Graves and Stokes, and their imperishable contributions to the literature of medicine, we would be led to believe that the healthiest type of instruction was conducted by the bedsides of their patients. "The principle in the new system of clinical teaching was diametrically opposed to that adopted

by the 'grinders' or 'crammers' of the past as well as of the present day." Alas for the shortcomings of the professional intellect and its attainments! The writer of this review has had some personal experience of "grinding;" during which he was often obliged, in the conscientious discharge of his duty, to correct the mistakes of an *un*-inspired clinical teacher, while preparing a pupil to receive the attentions of an examiner who was not unfrequently the most ignorant of the three seniors.

The conscientious and nervous energy which the young physician bestowed on the preparation of his first lecture is vividly portrayed in an extract from a letter bearing date April 15, 1826. From this time the career of William Stokes was an upward and onward one in the profession to which he had devoted his life. No exertion, physical or intellectual, was spared to bring him daily nearer the lofty goal which he had originally prefigured for his future. He never rested satisfied with present attainments; he went on adding culture to culture, and piling knowledge upon knowledge. He addressed his hospital pupils as fellow-students. We read of continuous daily work from half-past seven in the morning till twelve at night, complicated by the prevalence of a raging epidemic of typhus fever. We read of still unflagging devotion to the charms of poetry and romance, of architecture and painting, of music and the drama; to the beauties of landscape scenery, to the dreamy investigations of the archæologist, and to the social accomplishments of the *raconteur*. The many-faceted and highly-polished intellect of William Stokes was equally ready to receive and to reflect the brilliancy of genius as portrayed in the inspired Madonna of Raphael and the living impersonations of Helen Faucit, the dramatic mirrors of humanity bequeathed to us by William Shakespeare and the soul-stirring Scottish minstrelsy collected by Walter Scott, the simple structural grandeur of an Irish Round Tower and the exquisite Gothic network of the Antwerp Cathedral spire, which is said to have temporarily overpowered the senses of those mighty rulers of the earth—the Imperial and unprincipled religionist, Charles V., and the Corsican brigand, Napoleon Buonaparte.

Although not an active patriot in the epidemic sense to which the Johnsonian definition of patriotism is so truthfully applicable, Stokes perceived and mourned for the woes of his country, felt the fiendish injustice of the penal laws, and sympathised most keenly with the movement for Catholic Emancipation.

The details of advancement which medical education in Dublin received from William Stokes are too numerous to be even alluded to *seriatim*. His advocacy of Preventive Medicine, like many of his other spoken and written opinions, has turned out to be actually prophetic. The Diploma in State Medicine of the Dublin University was established as one of the results of his nobly philanthropic exertions; the establishment of the Dublin Sanitary Association was another. He defended the doctrine of the unity of Medicine and Surgery, and advocated the creation of corresponding degrees in the latter—a movement which has also had the best results.

His personal code of medical ethics was so high and noble that we must ever regret that he was unable to complete a projected work on this subject. We unhesitatingly say that every member of the profession would have been the better for the perusal of Stokes's fully-expressed ideas on this inspiring theme.

It would be but an idle—indeed, a presumptuous—waste of time and energy to attempt to examine in detail the vast number of important items of original research which have been contributed to the common stock of professional knowledge by the pen of our illustrious fellow-countryman. Merely a small portion of them have been even noticed in the pages of the memoir before us; but every reader of this journal should be acquainted with all of them. Microbes may come and microbes may go—some of us often pray that they soon may—and the same can be said of the toxins, ptomaïns, leucomaïns, &c., &c., which so profusely decorate the pages of our current clinical and pathological text-books; but so long as the human frame preserves its distinctive characteristics, we venture to prophesy that Stokes's classical descriptions of the symptoms which he

was the first to perceive, and the most eloquent to portray, will never lose their value for the clinical observer.

We congratulate the worthy son of a highly-gifted father on the way in which he has carried out the peculiarly delicate task which has been allotted to him. We would like to use more demonstrative language; but the example of true taste and delicacy of feeling which he has set us, and which we hope not soon to forget, makes us hesitate to say all that we would like to. We will only add—in concluding this notice of an inspiring life-history—that there is one name which will ever “echo down the corridors of time” as the Irish representative of the medical and surgical departments of the healing art for two generations of this, the most progressive of all the centuries, and that name is William Stokes! The respective owners of that name have borne the standard of advancing philanthropic science in Ireland, with the most comprehensive and far-reaching results, corresponding to those attained in France by Laennec, and in Great Britain by Simpson and by Lister.

Outlines of Practical Surgery. By WALTER G. SPENCER, M.B., M.S., F.R.C.S.; Surgeon to the Westminster Hospital. London: Baillière, Tindall & Cox. 1898.

THE delightfully short and admirably instructive preface with which the author introduces this volume to his reader includes but the three following short sentences:—“As the title indicates, this book on Surgery is limited to Practical Subjects. Details of Pathology and Bacteriology are best dealt with in special works. The same remark applies also to Ophthalmic Surgery.”

The worried reviewer, sated with the examination of prefaces and texts, is at once prepossessed in favour of the good sense and sound judgment, as well as modest dignity, of the at least semi-inspired author of this exemplary “Foreword.”

This handsomely bound and extremely well-printed volume is produced in the best style of the admirable series with which the eminent publishers, Messrs. Baillière, Tindall & Cox, are now preparing for the shelves of the

student and the practitioner. This handsome octavo of x and 694 pages, embracing as it does the whole range of practical surgery, with the small exception mentioned in the preface, is necessarily limited in the space devoted to any one of the enormous number of subjects which it embraces. Accordingly none of these can be said to be exhausted. But it gives an admirably outlined chart to guide the student in his reading, and to function as an *aide-mémoire* for the busy practitioner. We have no doubt that the author specially intended it to fulfil these purposes, and we cordially congratulate him on the way in which he has completed his self-imposed task. We know of no introductory guide-book to the ultra-labyrinthine mazes of practical surgery which we can so unreservedly recommend to the attention of the medical student and busy practitioner.

Manual of Operative Surgery. By H. J. WARING, M.S., M.B., B.Sc. (Lond.); F.R.C.S.; Demonstrator of Operative Surgery, and Surgical Registrar; late Senior Demonstrator of Anatomy, St. Bartholomew's Hospital, &c. Edinburgh and London: Young J. Pentland. 1898. Crown 8vo. Pp. 550, with 400 Illustrations.

THIS is an admirable book and we intend to recommend it to students, as, indeed, we have already done. The matter is well selected and the style clear and succinct. The anatomical descriptions and references are everywhere accurate, and we venture to suggest that still more anatomy might be safely instilled into future editions.

The author has been very wise in his arrangement of the book, placing the operations in that order which is likely to be adopted in an ordinary course of instruction on the dead subject. It is scarcely in harmony with the general plan to divorce Estlander's operation from operations on the pleura, and ligature of the middle meningeal artery and exposure of the lateral sinus from operations on the cranium. We do not agree with the author in regarding silk as the best ligature material for large arteries, and it is open to question if

it is well to teach that the ligature should rupture the middle and inner coats of the vessel.

The figure which illustrates amputation of the thumb does not accord very closely with the description in the text.

The illustrations of frozen sections of the abdomen on pages 141 and 147 are not quite as good as we could wish.

These are all, however, very minor points, and we would scarcely have drawn attention to them were it not that we feel a personal interest in the book for the reason that it is our intention, as already stated, to strongly recommend it as a text-book to students who may consult us in the matter.

A Manual of Operative Surgery. By LEWIS A. STIMSON, B.A., M.D.; Professor of Surgery in the University of the City of New York, &c.; and JOHN ROGERS, jun., B.A., M.D.; Assistant Demonstrator of Anatomy, Columbia College, New York, &c. Third Edition, with 434 Illustrations. London: H. K. Lewis, 136 Gower-street, W.C. 1897. Pp. 594.

THIS book is, we presume, intended, mainly at least, for students. Before expressing any view as to its merits it will be advisable to state what we consider we have a right to expect from any teacher of operative surgery. In the first place we, of course, look for a clear account of the operations themselves, special emphasis being placed on such details as apply to work upon the cadaver. The selection of methods is a most difficult and at the same time important element in this part of the subject. Secondly, we expect to find much attention given to anatomy, for, we believe, a lecturer on operative surgery has a great opportunity of adding much to a student's knowledge in this respect—indeed, we feel almost disposed to regard a course in operative surgery as an advanced course in surgical-applied anatomy. A third factor which requires as careful treatment as the two preceding is the general surgery directly associated with the various operations. We can conceive of no more difficult task than to give to each of these elements of the subject its appropriate place.

In the present book we think that the detail of operation

has been allowed to overshadow both anatomy and general surgery. The anatomical descriptions are not, in our opinion, satisfactory as a rule, and in some instances would sorely puzzle an English student. As an example note the following:—"Hunter's Canal; this name being given to the condensed sheath for a short distance above and below the point where it passes through the tendon of the adductor magnus."

In the accounts given of the anatomy of the arteries no mention is made of the collateral circulation. Why not? The indications and other matters of general surgical interest closely related to the operations are, as a general rule, unnoted. As we have already said, we think these matters should have a place, and the omission of them is one cause of want of attractiveness and vitality in the book. Surely nothing can excuse describing such an operation as craniectomy without giving some idea of the purpose of it. This particular procedure might, indeed, safely have been omitted from so small a volume; but that is another matter and leads us to the last point to which we would draw attention. If the book is intended, as we have assumed, for students the selection of operations should have been influenced by some such considerations as the following:—

Does this or that operation illustrate any important principle of surgical practice? Does it possess intrinsic practical importance, as is the case, for example, with tracheotomy? May it tend to develop manipulative skill (and this consideration will justify the inclusion of operations, such as pylorotomy, which have no other distinctly practical bearing)? Will it serve to impress on the student some important anatomical fact?

It must have been some consideration other than these which led the writers of this book to devote forty pages to plastic operations on the face, or fourteen to the plastic surgery of the urethra, and to dismiss amputation of the breast in considerably less than a single page. No better opportunity than that afforded by a discussion of this particular operation could be found to point out the principles which govern modern surgical procedure in the attempt to eradicate cancerous disease. No use has been made of the opportunity here, and it is, we think, an unfortunate fault

throughout the book that not enough is written to enforce principles and too much to describe details.

We have dwelt much on what we conceive to be the shortcomings of the work; but, of course, it contains a great deal that is excellent—enough to more than explain the necessity for a third edition.

RECENT PAPERS ON DISEASES OF CHILDREN.

1. *De la Paralysie Générale Progressive dans le Jeune Age.* Par le DR. CHARLES THIRY, Nancy. Paris. 1898.
2. *Transactions of the American Orthopædic Association.* Vol. X. Philadelphia. 1897.
3. *Transactions of the American Pediatric Society.* Vol. IX. Washington. 1897.
4. *Pediatrics.* Vol. V. Nos. 1 to 12. January to June, 1898 (fortnightly). New York and London.
5. *Archives of Pediatrics.* Vol. XV. Nos. 1 to 6. January to June, 1898. New York.
6. *Baby Feeding; or, How to Rear Healthy Children.* Advice to Mothers on the Rearing and Management of Children. Specially written for the Wives of the Working Classes. By a Doctor. Bristol: John Wright & Co. 1898.

1. General Paralysis of the Insane in children is an extremely rare and interesting disease. This is a beautiful and valuable review of all the available cases which have been truly and authentically published since 1877, occurring under twenty years of age. There are altogether 69 cases published, with clear and distinct notes of each. In 27 of these cases the disease was discovered in children under 14 years of age, and affecting all the periods of childhood down to 8 years, when the youngest case commenced, and died at 10 years. The fullest notes and most careful *post-mortem* details accompany this case, as also most of the remaining ones. To any one interested in this disease a most valuable fund of information is supplied by M. Thiry,

and at the end of the monograph is a series of beautiful plates of *post mortem* and microscopic appearances.

It is highly deserving of a good English translation.

2. These well-printed Transactions contain some interesting papers, amongst which are notably the following :—

- (a) "The Prognosis of Hip Disease under Efficient Treatment." By LE ROY HUBBARD.
- (b) "An Examination of the Human Gait." By E. H. BRADFORD.
- (c) "Round Shoulders."
- (d) "Measurements in Curvature of the Spine." By G. W. FITZ.

These will repay perusal, and are deserving of such publication.

3. These Transactions of the American Pediatric Society are for the most part of good value. The following are specially interesting papers :—

- (a) "The Evolution of Literature on Diseases of Children in the United States." By S. ADAMS. Setting forth chronologically the various works appearing there since 1789, when Benjamin Rush first wrote on influenza.
- (b) "On Epistaxis in Childhood."
- (c) "Varicella Gangrænosa."
- (d) "On Cerebral Abscess in Infants." By EMMETT HOLT.

4. *Pediatrics*, Vol. V., contains an interesting paper by Thos. Dolan on "Whooping Cough;" a Memoir, with portrait of the late Dr. Joseph O'Dwyer, of New York, the originator of "Intubation" in Diphtheria; and an elaborate paper on "Thermic Fever" in infants, in which the author holds that "Summer Diarrhœa" is in reality due to "Insolation" or "Sunstroke." We cannot, however, agree in this unqualified statement, though we fully recognise the undoubted connection between "Infective Diarrhœa" and warm weather. Other interesting

papers are—"The Hygienic Management of Dairies," by Dr. Brush, of New York; "The Municipal Control of Milk Supply in Cities," "Chronic Intestinal Indigestion," "Acute Gastro-enteritis," "Whooping Cough," and "Paralytic Imbecility," by Dr. Telford Smith.

5. *The Archives of Pediatrics* is an exceedingly well got up journal on diseases of children. We are at present not acquainted with any better. It emanates monthly from New York, and Vol. XV. contains the following valuable papers:—"Chorea," "Tetany," "The Diagnostic Value of Pain in Infancy" and "Habit Spasm," "Habitual Constipation in Infancy," and "Incontinence of Urine in Children," by M. M. Rochet and Jourdanet, of Paris.

This journal points in the right direction, but we think it would look much nicer and more high-class if advertisements were suppressed from the front of the cover.

6. *Baby Feeding*.—"To the many children who, through the ignorance or wilfulness of their mothers, have been doomed to a life of ill-health, misery, and poverty, this little pamphlet is dedicated, in sincere sympathy and with the earnest desire to show that even the poorest mother can bear a healthy child, provided that she knows how to do so, for no woman has a right to have a child unless she knows how to rear a child."

Our anonymous writer, who is a graduate of Dublin University, has given us some good pages on this subject.

The first chapter is a wholesome sermon or address to women. Ruskin is called in to aid our author in a eulogy of what good women might be; and he then proceeds in addressing mothers:—"Do you know that nearly all the delicate, wretched, unhealthy men and women on this earth are largely your products? They may have been born fine healthy children; but their mothers neglected them, they fed them improperly, starved them body and soul, and the result is that at the end of this nineteenth century, man, instead of being the strongest of animals, is the weakest and feeblest being in creation."

“Is it not time your slumbers were ended, and you awoke to the full sense of your duties? Look around at your handiwork, and see here a child blind at birth, due to want of cleanliness! Here a wretched bow-legged infant, with ‘rickets’ caused by bad feeding! Here a poor idiot with ‘water on the brain’ from the same cause. Awake! and see that such sights are banished from among you. Remember this: you may only be a working man’s wife; yet with the wages of a working man you ought to be able to rear strong, healthy children. Nature—or shall I say, Providence—has ordained that you should feed your offspring from the product of your own body. Nature has given you milk, and on this she intends you to rear your young, and in order to do so you have only to feed yourself, nature will do the rest. Learn to follow nature, learn to watch her, and to do as she tells you; and when she gives your child teeth wherewith to chew its own food she intends you to cease suckling the child, and to provide it with food more suitable to its altered conditions; it is then wanton waste to go on feeding it on your own life blood,” &c., &c.

Chapter II. reminds mothers, amongst other things, that the stomach of a young infant is not larger than “an ordinary hen’s egg,” and that “the only point in a baby’s anatomy which a mother ought to know is the size of its stomach, so that she may not overfeed it.”

Chapter III. contains sound advice on “the proper food for infants.”

Chapter IV. treats of “The New-born Baby.”

Chapter V. on “Weaning.”

Chapter VI. contains a list of dangers to be avoided. Some of these fall very wide of the subject of the book; for instance, “Do not marry till you are at least twenty years of age!” is rather *mal à propos*.

We think, after carefully reading over these pages, that they are much too “high class” for labouring people to profit by. They are much better fitted to instruct ladies and mothers in the higher grades of social life, and might be with benefit circulated amongst them.

As to the pamphlet itself, we think the cover and the

style of print outside are objectionable. They detract from its merits. At first sight, one is inclined to throw it aside into the waste paper basket, for its appearance is against it. Our anonymous friend should, if a second issue comes to light, see that his most useful pages are encased in a more attractive envelope. Books of this kind for public use are dangerous volumes to write, but our author has exhibited considerable tact and judgment. Moreover, he has at least made himself acquainted with some recent valuable papers on Diseases of Children, which is much to his credit, as it is to that of his volume.

An Atlas of Histology for the use of Students; being a separate issue of the 174 Original Coloured Illustrations from a "Text-book of Histology." By ARTHUR CLARKSON, M.B., C.M. Bristol: John Wright & Co. 1898.

A SHORT time ago we had the pleasure of calling the attention of our readers to the valuable Text-book of Histology by Mr. Clarkson, and of noticing particularly the extreme beauty and artistic excellence of the plates with which this work was illustrated. The author has now conferred a great boon on students and others whose means are limited by publishing the plates of his book separately as an Atlas, at the very moderate price of nine shillings. The very handy volume consists of 88 plates, containing 174 coloured figures, with explanatory text. It is one which cannot be too highly recommended to every one who is engaged in practical histological work.

A Treatise on the Pathology, Diagnosis, and Treatment of Neuroma. By ROBERT W. SMITH, M.D. London: The New Sydenham Society. 1898.

THIS remarkable work was published in a very small edition in 1849, is now in the hands of very few, and is very difficult to obtain. Its value is far too great to allow it to remain out of print, and therefore the New Sydenham Society has acted wisely in undertaking its republication as a part of the valuable Atlas of Illustrations of Pathology. As said by

the editor in his preface, "So carefully recorded are the observations that their value is as great as at the time of original publication, and the reader will be struck by the practical absence of anything that seems antiquated."

Neuromatous tumours are divided by Professor Smith into spontaneous and traumatic. The former are usually single, and when so are painful, but when multiple are usually free from pain. The traumatic are almost always extremely painful. The general characters and symptoms of idiopathic neuroma are described in a masterly manner, and with a clearness and conciseness that will be familiar to those who have had the privilege of attending Professor Smith's lectures, or who have read his other works, and which might be well taken as a model by many modern writers. The diagnosis of painful neuromatous tumours is thus summed up:—"The oval or oblong form of the tumour, its being moveable from side to side, but not in the direction of the nerve upon which it is placed, the attempt to move it in the latter direction being productive of severe pain, its freedom from adhesion to the surrounding structures, the healthy condition of the integuments, the extraordinary sensibility of the tumour, the peculiar electric character of the pain, its terrible severity, paroxysmal type, and extension along the trunk and branches of the nerve, constitute a group of symptoms which, in the majority of cases, are sufficient to establish the true nature of the tumour."

In the treatment, which is entirely operative, the attempt to dissect the tumour away from the nerve is condemned except in very exceptional cases. Excision of the tumour and of the piece of nerve from which it grows has in many cases been followed by the happiest result. Not only has the pain been removed, but after a time the functions of the parts supplied by the divided nerve have been completely restored. This has been the case in removal of tumours of the ulnar, median, posterior tibial, and even the sciatic nerves. Many cases from the author's own practice and from that of other surgeons are recorded, illustrating the good results of this method of treatment. As a permanent result, following division of the nerve, Dr. Smith notices a peculiar coldness of the part supplied by it.

In the section on multiple neuromatous tumours some cases are quoted from Descot, Schiffner, Wutzer, Knoblauch, and Barkow. In most of these the patients were idiotic or insane, or suffered from organic disease of the brain. But this was not the case in either of the two remarkable instances of multiple neuromata observed by Professor Smith himself, the accurate clinical histories and autopsies of which are the chief features of this remarkable treatise. The beautiful dissections of the nerves in these cases, and the admirable casts, illustrating the appearances both before and after dissection, will be remembered by all the old students of the Richmond Hospital. They were among the treasures of the museum of that institution, but are now, unhappily, buried in the lumber-rooms of the Royal University, where no one can see them or make any use of them.

Multiple neuroma, where the tumours are very numerous, is a very rare condition. Virchow, in his *Onkologie*, states that there are only 30 cases on record; he himself had never seen a recent case. Dr. Smith had occasion to observe two cases within the same year, and gives a most complete account of them, illustrated by very fine drawings. They were both men between thirty and forty years of age; in both the disease had lasted a considerable time. One died of marasmus, the other of gastro-enteritis. In both nearly all the nerves were occupied by tumours of various sizes, from those scarcely perceptible to some that were of very large size. One, on the left sciatic nerve of M'Cann, "occupied the posterior surface of the nerve from the lower margin of the glutæus maximus to within four or five inches of the centre of the popliteal space. The vertical diameter was eleven inches, and its transverse ten. The extent of its surface from above downwards measured fifteen inches, and from side to side one foot and a half." In all these tumours it was apparent that they grew from the connective tissue of the nerves, and that the nerve-fibres were spread out over the mass. They were what is called false neuromata. Dr. Smith did not neglect the microscopic examination of these growths, and found them to be composed "essentially of a fibro-cellular structure, the fibrous tissue predominating in by far the greater number, the areolar preponderating in

a few. The fibres were arranged in bands or loops, among which permanent oval or elongated nuclei became apparent on the addition of acetic acid. In no one instance out of the numerous specimens examined, was there any trace discovered of nerve-tubes, nor any indication whatever of the presence of any of the structures considered by modern pathologists as characteristic of malignant disease." Virchow thinks these tumours are fibro-neuromata, and they are now generally considered to originate in the endoneurium, between the nerve-fibres.

It is interesting to contrast the drawings of the microscopic appearances as figured by Dr. Smith (Plate XV., Figs. 11 and 12) with those given in modern works on pathology, as illustrating the advance in histological technique within the last fifty years.

The number of tumours found on the nerves of the two cases of Dr. Smith was enormous. In the first case (M'Cann) there were upwards of 800; in the second (Lawlor) there were at least 2,000.

The traumatic neuromata form the subject of the latter part of the treatise, and are dealt with in the same magistral style as are the idiopathic forms of the disease.

Dr. Smith's knowledge of pathological literature was notorious, and is shown by the bibliography appended to this work.

The plates, fifteen in number, have been reduced to one-half their original size, but their beauty and fidelity remain unimpaired.

The Blood; How to Examine and Diagnose its Diseases. By ALFRED C. COLES, M.D. London: J. & A. Churchill. 1898. Pp. 260.

THIS is a book which, although it does not contain much that is new or original, will be found useful by anyone who is engaged in microscopic investigations on the blood. The methods of counting the corpuscles, of estimating the hæmoglobin, and of examining the corpuscles, both in fresh specimens and in fixed and stained films, are carefully and fully described.

An account is given of the general morphology of the red and white corpuscles and blood platelets, and then the pathological conditions of the blood are described in a series of chapters. These are chiefly the different forms of anæmias, which are divided into primary and secondary. Among the former a short chapter is devoted to splenic anæmia, in which there is diminution of red corpuscles, a still greater diminution of hæmoglobin, no alteration in the white corpuscles, enlargement of the spleen, no enlargement of the lymphatic glands. The diagnosis is said to be of importance, as there is some evidence that the usually fatal termination may be prevented by removal of the spleen.

A useful table is given showing the alterations in the different elements of the blood which occur in, and are characteristic of, the varieties of anæmia.

The second part of the work deals with the secondary anæmias—those met with in malignant diseases, in purpura and other hæmorrhagic diseases, and in malaria. In this section a good account is given of the malaria parasites, and the methods which should be employed for their examination. The condition of the blood in acute diseases is next described, and here directions are given for making the serum diagnosis of typhoid fever. The blood changes in chronic infectious diseases, as syphilis and tuberculosis, and in various general diseases, as diabetes, gout, myxœdema, are then described, while the anæmias which occur in early life are the subject of the last chapter. In this we find an account of the disease described by v. Jaksch as anæmia infantum pseudo-leukæmica, characterised by marked enlargement of the spleen, and at times slight enlargement of the lymphatic glands and liver. There is pronounced oligocythæmia, the red corpuscles falling below 3 millions, and sometimes below 1 million; nucleated red cells are common. There is persistent and pronounced leucocytosis, the white corpuscles rising to from 40,000 to 114,150, and the proportion of white to red being as high as 1-12 or 1-20. The leucocytes are usually chiefly of the multinucleated variety, but sometimes the uninucleated predominate; marrow cells are sometimes present in small numbers; eosinophile cells are sometimes increased, sometimes diminished. As to the nature of the

disease, Dr. Coles says: "I cannot help regarding some forms of anæmia infantum pseudo-leukæmica as similar to the so-called splenic anæmia of adults, and am of the opinion that both may be mere varieties of Hodgkin's disease or of pseudo-leukæmia."

A list of references to books on the diseases of the blood and a good index conclude the volume. There are six well-executed coloured plates, showing the appearances described in the text.

We have only to repeat that this will be found an extremely useful book, and should be in the hands of all those who desire to work at the subject with which it deals.

Journal of the Scottish Meteorological Society. Third Series. Vol. XI. Nos. XIII. and XIV. With Tables for the years 1895 and 1896. Edinburgh and London: William Blackwood & Sons. 1898. 8vo. Pp. 248.

THERE can be no doubt that these are the most important and valuable numbers of the *Journal of the Scottish Meteorological Society* which have yet been published. Fifteen years ago the Meteorological Secretary, Alexander Buchan, LL.D., F.R.S. Edin., contributed two papers on the Atmospheric Pressure and Temperature of the British Islands, based on the observations made during the twenty-four years ending with 1880. He did, in a word, for the two elements of climate just named what Mr. G. J. Symons, F.R.S., has done for rainfall in his well-known work "*British Rainfall*."

Dr. Buchan has now revised his great work, and has prepared a paper from observations during forty years, from January, 1856, to December, 1895. It is to the appearance of this masterly communication that the numbers of the *Journal* before us owe their exceptional value. The number of stations for which averages have been obtained are 176 in England, 194 in Scotland, and 30 in Ireland—in all, 400. These include all, or nearly all, the places at which trustworthy observations have been made for the forty years, or such number of years from which good

averages could be deduced. Dr. Buchan's paper is illustrated by a series of twenty-six beautiful coloured maps.

Mr. J. Y. Buchanan, F.R.S., contributes a paper on the determination of the temperature of saturated steam and the production of higher fixed temperatures by the condensation of steam on salts and in saline solutions. Mr. R. C. Mossman, F.R.S.E., gives a history of the displays of aurora borealis in London from 1707 to 1895. Mr. R. T. Omond describes the change of temperature with height during anticyclones on Ben Nevis and at some Continental stations.

The remainder of these numbers is taken up with reports from the Council of the Scottish Meteorological Society, additional returns of rainfall for 1895 and 1896, meteorological returns for those years from Scottish lighthouses, and the usual tables illustrative of the meteorology of Scotland in 1895 and 1896.

Archives of the Roentgen Ray: Edited by W. S. HEDLEY, M.D., and SYDNEY ROWLAND, M.A., M.R.C.S. Vol. II. No. 4. May, 1898. London: The Rebman Publishing Company. 1898.

THE contents of this number of the *Archives* are many and varied. The Plates are of exceptional interest. In Plate XLI. are two skiagraphs. The first represents the normal hand and arm of a married lady—married, because we see the wedding ring and its guard-ring; a lady, because of the delicacy of the hand and fingers. The second shows the lower part of a leg riddled with shot. Plate XL. is by Dr. C. Lester Leonard, radiographer to the University of Pennsylvania Hospital, and illustrates the localisation of foreign bodies in the eye by means of the X-rays.

The remaining radiographs are of enlargement of the humerus, osteo-sarcoma, renal calculi, ossifying sarcoma, and of bony union in progress. This last case is a remarkable one. There are three radiographs—the first shows a fracture of the first phalanx of the middle finger; the second, commencing bony union; and the third, complete union.

The editors are to be congratulated upon the excellence of this number of the *Archives*, a publication which has evidently supplied a want in medico-chirurgical literature.

The Edinburgh Medical Journal. Edited by G. A. GIBSON, M.D., F.R.C.P. Ed. New Series. Vol. III. Edinburgh and London: Young J. Pentland. 1898. 8vo. Pp. 672.

DR. GIBSON is a first-rate editor, and is happy in having such a publisher as Mr. Young J. Pentland.

The third volume of the new series of this old-established medical periodical contains no less than thirty-six original articles on almost every branch of medical science.

The other features in the volume are analytical reports on various dietetic and medicinal preparations, reviews of British and foreign medical literature, reports on recent advances in medical science, reports of medical societies, obituary notices, and monthly notes on meteorology and vital statistics. The last are under the management of Dr. A. Lockhart Gillespie. F.R.S.E., F.R.C.P. Ed., Member of the Scottish Meteorological Society.

The *finish* of the volume is all that can be desired.

Burdett's Hospitals and Charities, 1898. Being the Year-Book of Philanthropy and the Hospital Annual. By SIR HENRY BURDETT, K.C.B. London: The Scientific Press. 1898. 8vo. Pp. 1071.

THE present issue of Sir Henry Burdett's valuable guide to hospitals and charities possesses special interest for all who have at heart the welfare of the sick and convalescent. The opening chapters tell of the effect of the celebration of the "Diamond Jubilee" of Her Most Gracious Majesty, Queen Victoria, on the resources of the voluntary charities in the United Kingdom, and discuss the volume of charity in 1897, and other topics relating to that memorable year.

The special Jubilee efforts made for hospitals and kindred institutions throughout the Kingdom resulted in a subscription of no less than £938,041, and the acquisition of a revenue of

£25,000 a year from annual subscriptions. These vast sums have been raised at an average cost of just over *one per cent.*—an astonishing result, which proves that the money is directly due to the sentiments evoked by the Diamond Jubilee celebration.

We are glad to see by a table given at page 61 that the amount raised in Ireland in response to the Jubilee appeals was as much as £103,862, the expenditure on appeals being only £893, or 0·8 per cent.

Seeing how valuable a book of reference this is, it is much to be regretted that in Dublin alone the House of Industry Hospitals, Mercer's Hospital, the National Lying-in Hospital, St. Vincent's Hospital, the Throat and Ear Hospital, and the Westmoreland Lock (Government) Hospital neglected to make any return, although repeated applications for information had been made to their respective responsible officers.

The work contains information about all sorts of kindred institutions, including nurses' homes, and so on. It is a very encyclopædia of information relating to hospitals, asylums, general charities, nursing institutions, and medical schools.

The Meath Home of Comfort for Epileptics, Westbrook, Godalming, Surrey. Fifth Annual Report for the Year ending 31st December, 1897. Godalming: R. B. Stedman. 1898. Pp. 31.

THE object of this excellent institution, which was founded some six years ago, is to provide a home for epileptic women and girls, from the age of two to that of thirty-five years. Inmates are chosen from all parts of the Kingdom, irrespective of religious creed. The "Home of Comfort" is supported in part by voluntary contributions; it is partly self-supporting. The treatment pursued is based, as far as possible, upon the provision of suitable occupations for the individual patients.

The names of the Earl and Countess of Meath, and of the Lady Kathleen Brabazon—Lord Meath's only sister—are found in the list of the working committee.

The medical officer, Mr. P. Dundas Minchin, L.R.C.P. Ed., writes the fifth annual medical report of the Home, from

which it appears that during 1897 there were 31 fresh admissions, compared with only 15 in 1896. Thirteen inmates left during the year, 6 of which were quite unsuitable cases, and should never have been sent to the Home, which is not suited for very advanced cases, or for cases where there is any decided mental deficiency.

As to the epileptic condition of the patients the striking feature continues to be the marked initial improvement after admission, both in the frequency and character of the attacks. This improvement in the large majority of cases continues to be maintained, and in a short time the girls, from being a misery and a burthen both to themselves and to others, begin to realise that not only can they be useful members of society themselves, but that they can also to a large extent assist their more helpless sisters in affliction.

Doctors and Patients: Hints to Both. By DR. ROBERT GERSUNGY. Translated by A. S. LEVETUS, with a Preface by D. J. LEECH, M.D. Bristol: John Wright & Co. 1898. Pp. 79.

THIS interesting book gives in a pleasant, readable way the opinions of a distinguished member of the profession in Vienna on medical ethics. It is extremely well written, free from diffuseness, and illustrative cases are only lightly treated, so as to emphasise the author's contentions. We can recommend this book to medical men and patients as setting out pleasantly and clearly the relations that should exist between them, and feel sure that if read it will lead to an increase of mutual liking, respect, and give-and-take.

A Manual of Practical Medical Electricity. By DAWSON TURNER, M.D., F.R.C.P. Ed. Second Edition. London: Baillière, Tindall, & Cox. 1897. Pp. 335.

IN general arrangement this follows the plan of the first edition, but several slight alterations for the better have been made, and twenty pages and twenty-three excellent illustrations have been devoted to the X-rays. The book is divided into parts, which deal respectively with electro-

physics, electro-physiology, electro-diagnosis, electro-surgery, and electro-therapeutics—a rational and convenient classification, which renders it an easily used handbook by the practitioner. Whilst the author has avoided the common error of padding his book with the well-worn history of the earlier discoveries concerning electricity, he has not fallen into the opposite error of assuming previous knowledge in his readers, but has written his work in clear and simple language, defining and explaining the terms used, and freely illustrating the apparatus required for the medical and surgical use of electricity.

Synopsis of The British Pharmacopœia. 1898. Compiled by H. WHIPPELL GADD. London: Baillière, Tindall & Cox.

THE aim of this little book is to show in what way the British Pharmacopœia of 1898 differs from that of 1885, and also to give a complete synopsis of the new work.

It is one of the first of the synopses issued, and consists of 183 pages of accurate and useful information, and can be carried in the waistcoat pocket. The price is only sixpence.

The Extra Pharmacopœia. Revised in accordance with the "British Pharmacopœia," 1898. By WILLIAM MARTINDALE, F.L.S., F.C.S., Member of Council of the Pharmaceutical Society and late Examiner. Serotherapy, Organotherapy, Medical References and a Therapeutic Index. By W. WYNN WESTCOTT, M.B. Lond., H.M.'s Coroner for North-East London. Ninth Edition. London: H. K. Lewis. 1898. Pp. xxviii + 626.

THE cardinal point to remember in connection with the ninth edition of this truly excellent little book is that it has been revised in accordance with the new British Pharmacopœia, in the compilation of which one of the authors, Mr. William Martindale, has borne an honourable and most useful part,

In the present Edition of the "Extra Pharmacopœia"

are to be found new monographs in miniature on aloes, calcium chloride, chelidonium, digitalis, compounds of mercury and of iron, mustard, opium, orange, rose, mescal buttons, and other drugs. Mescal buttons are the fruit of the *Anhalonium Lewinii*, and are used by the Mexican Indians to produce intoxication accompanied by visions.

While this book serves as an admirable pocket commentary on the British Pharmacopœia, it also gives numerous details as to the newer unofficial remedies, together with references to their use. Among the new synthetic compounds which are mentioned we find eucaïn, holocaïn, orthoform. Erythrol and mannitol nitrates and other similar novelties are described and their therapeutic power is discussed, so that the information is fully up to date. In the formula for "Tinctura Laxativa" at page 121 the altered strengths of the official tinctures of nuxvomica and belladonna has necessitated an alteration at the last moment. The new (neutral) gender of pepsin has led to a little inconsistency under the heading "Pepsinum," where we read of "Pepsina Amylacea" and "Vinum Pepsinæ."

We congratulate the authors on the promptness with which they have been able to publish this ninth edition of their most useful companion to the Pharmacopœia.

The Mineral Waters and Health Resorts of Europe. Being a revised and enlarged Edition of "The Spas and Mineral Waters of Europe." By HERMANN WEBER, M.D., F.R.C.P.; and F. PARKES WEBER, M.D., F.R.C.P. London: Smith, Elder & Co. 1898. 8vo. Pp. 524.

THE first edition of this admirable work quickly won for itself a deserved reputation as a reliable and pleasantly-written text-book and guide to health resorts and watering places. In the present edition the authors have introduced many alterations and made many improvements. Two fresh chapters (XVIII. and XIX.) have likewise been added. In the former of these inland climatic health resorts are described and classified. The latter gives a short account of "grape-cures," dietetic cures, and sana-

toria for special methods of treatment for pulmonary consumption.

In proof that the work is thoroughly up to date, we may mention that argon is described (page 17) as being present in the thermal waters of Bath, Buxton, Wildbad, and so on. Argon, say the authors, is doubtless present in waters which are fairly rich in free nitrogen. The gas "helium," previously to its discovery in certain minerals in 1895 by Professor Ramsay, had been known to exist only by its band in the spectrum of the solar chromosphere. Shortly after Professor Ramsay's discovery it was found to be present in association with argon in the waters of Bath and in some of the Cauterets waters. The authors consider that it is very unlikely that nitrogen, argon, or helium in the Bath or Cauterets water exerts any special therapeutic effect. Still, in spite of theoretical grounds, they admit that it is not quite impossible that such an effect may be produced by these elements.

In the fourth chapter we are glad to find that the authors, when discussing exercises and massage at spas, justly attribute to William Stokes the credit of advocating the use of exercise in certain heart affections.

Chapter V. gives an excellent account of daily life at spas. The importance of medical supervision while undergoing the "cure" at spas is very properly insisted upon, and illustrated by a graphic description of that disturbance of the system known as "Well-fever," "Bad Friesel," "Fièvre thermale," "Crise thermale," or "Poussée thermale."

The succeeding chapters are devoted to the different classes of mineral waters. Simple or indifferent thermal waters, muriated or common salt waters, simple alkaline, muriated alkaline, sulphated alkaline, sulphated and muriated-sulphated iron or chalybeate, arsenical, sulphur, and earthy or calcareous waters are all in turn described and illustrated—Russian and Hungarian spas being included. Mention should be made of the very comprehensive spa-map of Europe, which will be found in a pocket in the back cover of the book.

In Chapter XVI. the authors describe the various

natural "table-waters," which are defined (at page 320) as "feebly mineralised waters, usually containing a large quantity of free carbonic acid gas." They may be of some use in medicine, but they "are more frequently used for ordinary drinking at meals, or for refreshing draughts between meal-times, than for strictly medical purposes." We are thoroughly in accord, however, with the authors' opinion that "much of the temporary popular preference of particular 'table-waters' over others depends on mere fashion and advertisement."

"Marine Spas and Health Resorts" form the subject-matter of the seventeenth chapter, which is very entertaining and instructive. Our fellow-countryman, Dr. D. Edgar Flinn, is quoted as *the* authority on Irish Health Resorts, the second edition of his bright little work on "Ireland: its Health Resorts and Watering Places," published in 1895, being quoted as a text-book in the bibliography at the end of the volume.

The foregoing are but a few among the many interesting topics discussed in this book—a book which will enhance the reputation of its authors, and (we may add) of its publishers as well.

The Medical Examination for Life Assurance; with Remarks on the Selection of an Office. By F. DE HAVILLAND HALL, M.D., F.R.C.P.; Physician to, and joint Lecturer on Medicine at, the Westminster Hospital; Physician to the Rock Life Assurance Company. Bristol: John Wright & Co. London: Simpkin, Marshall, Hamilton, Kent & Co., Limited; Hirschfeld Bros. 1898.

IN this booklet of 73 pages the author gives the reader the more important items of information for the guidance of those members of the profession who are called upon to make physical examination of the persons who submit themselves for scrutiny to the officials of the Insurance Companies. He regards the individual in each of those cases from four principal points of view:—I. Family history; II. Personal history; III. Present condition; IV. Environment. To the text are appended specimens of

the forms used for the confidential reports of the medical examiner; Dr. Leslie Ogilvie's table of the classification of assurance lives, with illustrative types—with an explanatory note, and an index of assurance offices. There is a very good index at the end.

Report on Bubonic Plague. Being a Report based upon Observations on 939 Cases of Bubonic Plague treated at the Municipal Hospital for Infectious Diseases at Arthur-road, Bombay, from September 24th, 1896, to February 28th, 1897. By KHAN BAHADUR N. H. CHOKSY, Extra Assistant Health Officer, Bombay Municipality. (Reprinted by authority.) Bombay: Printed at the *Times of India* Steam Press. 1897.

THE facility afforded to the author of this report for collecting statistics is shown by the fact that "during January and February, 1897, 642 plague cases were treated." The following is the classification adopted of the "Types of Plague":—

- "1. *Pestis Minor, or Extremely Mild Plague.*
2. *Pestis Ambulans.*
3. *Pestis Simplex Bubonica, or Simple Bubonic Plague.*
4. *Pestis Septica, or Septic Plague.*
5. *Pestis Pulmonalis, or Pneumonic Plague.*
6. *Non-typical Forms of Plague.*"

"Besides the above, two other forms of Plague—Abdominal and Laryngeal or Diphtheritic—have been mentioned; no cases of the abdominal type have been observed in this hospital. The laryngeal type, if it could be so called, was observed not so much as a distinct entity, but more as an advanced form of deep cervical buboes, with infiltration in the connective tissue of the neck, spreading right on up to the pharynx and larynx, and involving them in the same process. But no cases of a simple laryngeal type were observed."

Of the six varieties so tabulated, the first and second have no fatal results. The third and fourth are the forms which are specially characteristic of the plague. "So long as the bacilli are confined to the lymphatic system alone,

without infecting the blood, the case may be called simple bubonic, but once the blood is infected and graver symptoms develop with infection of other glands, extensive infiltrations, &c., the case becomes septic." The author's view accordingly is that "the differentiation between the simple bubonic and septic forms is a question rather of degree than of kind, depending as it does upon whether the plague bacilli infect or do not infect the blood." In the fifth variety of plague "the lungs seem to be primarily infected, resulting in a peculiar form of lobular pneumonia quite characteristic of the affection. It has been assumed that the pneumonia here is a primary pneumonia as distinguished from the secondary form which appears in some cases of plague after the buboes have become fully developed."

With regard to the mode of absorption of the virus, "in not more than 5 per cent. of cases could direct evidence of infection through breaches of surface be traced, and this is really inconsiderable when it is remembered that most of the patients admitted were in the habit of going barefooted all their lives, and had innumerable cracks and fissures on the soles and elsewhere."

With regard to microbic growth—"The pus from incised buboes was always found on the first day to contain a large number of plague bacilli;" and "the sputum in cases of pneumonia, primary or secondary, has been observed to contain almost pure cultures of plague bacilli." Having regard to the latter fact, it at once "led to the conclusion that there was direct infection through inspiration." The writer of the present report, however, decides that "ordinary respiration, or rather expiration of plague patients, does not seem to infect, for if it did scarcely a doctor, nurse, or hospital attendant would enjoy the immunity that they have hitherto done." We are further informed that "infection through the stomach appears to be doubtful;" and that "in no case was the plague attributed to rat-bite, either immediately or some time previous to infection. And as regards flies and fleas, ants, bugs, and even mosquitoes, however enticing the theory appeared as tending to solve a difficult problem, it was more fanciful

than real, appealing, as it did, more to the imagination than to reason and common sense."

The period which elapsed before the development of the symptoms was, as would be expected, very hard to even guess at; but we are told that "from careful inquiry from intelligent patients it was found that generally the period of incubation was from three to six days."

The *aspect* and *speech* of the patients who presented themselves at the hospital were diagnostically characteristic. The author of this report is a firm believer in the *facies pestica*. With regard to the decubitus: "If recumbent they generally lay flat on the back, with the limbs extended, and almost invariably one leg crossed over the other."

But we have already occupied too much space with our extracts. We will accordingly conclude by recommending every reader who is at all interested in this gruesomely fascinating subject to read this valuable report for himself.

The Subconscious Self, and its Relation to Education and Health. By LOUIS WALDSTEIN, M.D. London: Grant Richards. 1897.

THIS beautifully printed volume of Dr. Waldstein's forms an interesting addition to the important series of "New Scientific Books," which, to say the least, do great credit to the good taste and selective judgment of the publisher.

The author uses—very ingeniously, and with a full knowledge of the physiology of the nervous system—the item of the "Subconscious Self" to explain the phenomena of early impressions, prejudices, religious beliefs, hypnotism, hysteria, insanity, worry, &c. The points at issue are so varied and so important that we cannot give full reasons for the impressions we have received from the perusal of this volume within the limits of a short review. We therefore recommend our readers to judge for themselves. They will find material enough for profound suggestion in this comparatively small volume (of 171 pages).

PURVEYORS TO H.R.H.



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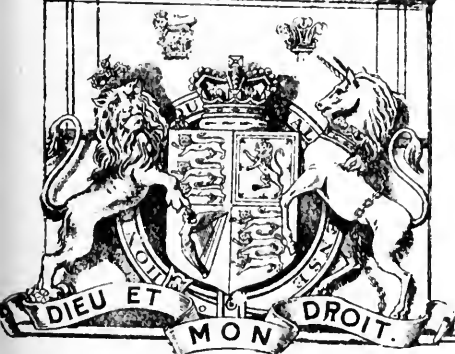
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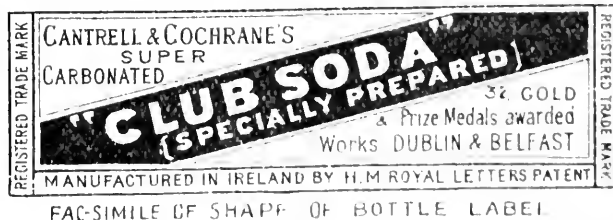
WATER OF HEALTH

HYGEIA

GODDESS OF HEALTH.

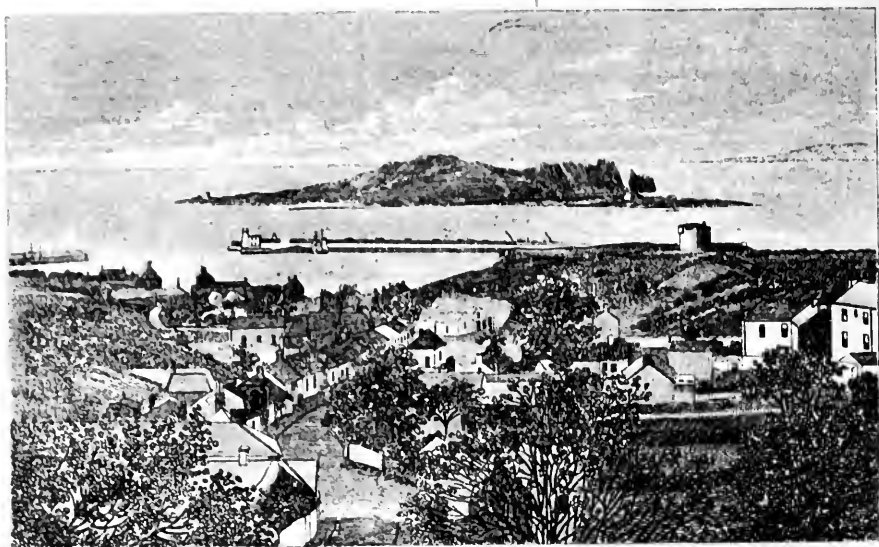


SIR CHARLES CAMERON SAYS: "CLUB SODA" NEUTRALIZES THE LACTIC ACID IN THE BLOOD WHICH GIVES RISE TO RHEUMATISM & OTHER AFFECTIONS. IT IS AN ANTIDOTE TO ACID DYSPEPSIA, AND PROMOTES DIGESTION AND IS THE MOST WHOLE-SOME DAILY BEVERAGE THAT CAN BE TAKEN."



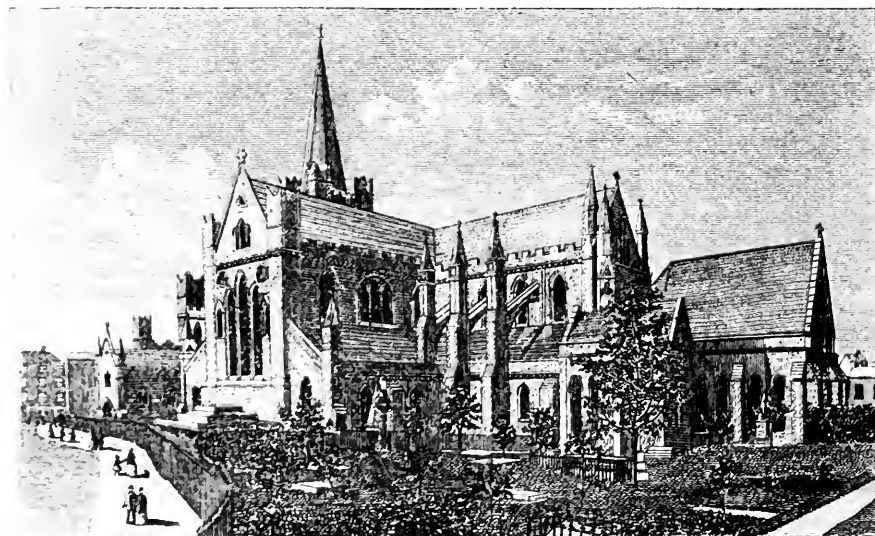
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ST. PATRICK'S CATHEDRAL

PART III.

MEDICAL MISCELLANY.

Reports, Transactions, and Scientific Intelligence.

Rash of Influenza Simulating Typhoid. By DR. PELON, of Montpellier.
Translated by GEORGE FOY, M.D., U.C., Va.; F.R.C.S.; Hon.
Fellow of the Southern Surgical and Gynecological Association,
U.S.A.; Member of the Society of Anæsthetists, London;
Surgeon to the Whitworth Hospital, Drumcondra.

DR. PELON (*Gazette des Hôpitaux*) writes:—Influenza is frequently accompanied by cutaneous eruptions, and these generally assume the characters of urticaria, herpes, or roseola. Sometimes they resemble the eruption of variola, scarlatina, or erysipelas. When present they may become a source of error in diagnosis. One eruption which I have occasionally met with, which is more liable to cause an error in diagnosis than any of the others, is the eruption of lenticular rose spots, such as are met with in the course of typhoid fever. Professor Teissier, of Lyons, was one of the first to draw attention to this eruption in influenza, in a paper in the *Lyon Médical*, in June, 1892. In the same year Professor Lemoine, of Lille, and M. Delezenne, now Professor in the Medical School of Montpellier, considered this form of rash not infrequent in the disease. I have had occasion myself to notice this winter, during a rather severe epidemic in our city, three cases of influenza with the typhoid lenticular rose rash. The three cases I propose to briefly report were treated at a suburban hospital of Montpellier, under the care of Professor Carrieu, for whom Dr. Ranzier was then acting.

CASE I.—R., a soldier of the 122nd regiment of infantry, came under care on the 25th of January, with influenza. Three days previously he had a rigor whilst at exercise. Headache very severe, and pain extended down to the nape of the neck. Epistaxis, of a not severe type, followed. The patient commenced paroxysms of coughing, and suffered from a sharp purging: six stools a day. On examination the patient was found greatly dejected. His tongue was typhoid like; covered with a creamy fur on its greater

part, but with a red tip and border. The belly was greatly swollen with wind, but pressure in the iliac regions gave pain. He presented some lenticular rose spots, which, though not numerous, were well marked; none were observed on the chest. Auscultation detected nothing more than a slightly roughened breathing. The evening temperature was 105° F., and in the morning it was 101.2° F. The pulse was 96. The diagnosis was typhoid fever. The serum test for diagnosis was made during the day. On the 27th the symptoms were less marked, the diarrhœa had ceased, but the rash was very typical and clear, and the temperature varied from 103° to 101° F.

On the 29th the temperature fell, the tongue assumed its normal appearance, and the rose spots disappeared. The cough was now accompanied by a muco-purulent sputum, and subcrepitant râles were heard along the bases of the lungs. The serum test gave negative results. The diagnosis was changed to influenza.

On the 31st the patient was practically well; there was no return of the fever, and the cough was much easier.

CASE II.—V., a soldier of the 122nd regiment of infantry, admitted on the same day as the previous case, also with the diagnosis of influenza. He said that eight days before he took sick, with a violent colic and sharp purging. The patient, amongst other ills, complained of a severe headache. He also had a severe cough with some sputum, and loss of appetite. On admission he was found to be suffering from megrim, was very weak, and had a violent headache; he was purged six or seven times a day. Pressure over the iliac fossæ caused pain. The tongue was red on its tip and borders, but covered with a creamy fur on its centre; the cough was frequent and accompanied by a free muco-purulent discharge. Auscultation recognised disseminated sonorous and sibilant râles throughout the lungs. The temperature ranged from 104.5° F. to 101° F. The pulse was 90. Over the belly and chest the typical rose-rash of typhoid fever extended. The diagnosis was typhoid fever with general bronchitis.

On the 27th the temperature fell, the diarrhœa lessened, but the tongue was unchanged; the respirations became harsh, and the rash remained abundant and typical. The serum test gave no result.

On the 29th the temperature fell, the patient is better, he suffers less from his head and belly, the rash persists, the cough continues, and subcrepitant râles are heard along the bases of the lungs. We now made a diagnosis of influenza attacking the intestinal tube primarily, with attendant bronchial troubles.

On the 31st the fever has left, the cough is less severe, the patient is well, but the typhoid-like rash is still present.

CASE III.—B., a house-keeper, thirty-eight years of age, was admitted on the 26th of January. Complains of a great sense of weariness during the past month, has experienced pains in her legs and suffers from a violent headache, which is worse at night. The thought of syphilis was quickly dispelled by the history of the case. During the past week the feeling of weakness had greatly increased, and the headache is unbearable, the voice is lost. The patient has a severe cough with phlegm, she has lost her appetite, and is very constipated. For two days past she has suffered a sharp pain in the left side of the thorax.

On admission her temperature was 103.8° F. When examined the patient was found to be very prostrate. The tongue was large, soft, coated with a red tip and borders. The two iliac fossæ are painful, more particularly the right one. Auscultation discovered blowing respiration along the bases of the lungs, better marked on the left than on the right side. Temperature in the morning marked 102.2° F.; the pulse 116. The lower margin of the thorax and the front of the belly were covered with a well-marked typhoid rash.

The diagnosis of the case formed the subject of discussion, and after considering the symptoms and giving due weight to its points of resemblance to influenza, it was registered as typhoid fever.

On the 28th the same test was negative in its results, and an examination of the sputum detected no bacilli of tubercle. The temperature rose to 103° F., and the following morning fell to 101° F. The pulse fell to 100. After a purge the bowels freely acted, the patient passing several large stools; the tongue remains unchanged; the rash is more abundant and very clearly marked.

February the 1st.—After three days the temperature is still 99° F.; the cough is less; there is no headache; the tongue has assumed its normal character, but the rash persists, the earlier spots disappearing and being replaced by fresh crops.

6th.—The rash has ceased to appear. The patient is still very weak, but can take food.

ULCERATED CHILBLAINS.

DR. J. DE MONTMOLLIN (*Rev. Méd. de la Suisse Romande*) recommends the ulcerated chilblains to be bathed for 15 or 30 minutes four times a day with a weak tepid solution of tannic acid. He reports some successful cases by this treatment.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

President—EDWARD H. BENNETT, M.D., F.R.C.S.I.
General Secretary—JOHN B. STORY, M.B., F.R.C.S.I.

SECTION OF OBSTETRICS.

President—F. W. KIDD, M.D.
Sectional Secretary—J. H. GLENN, M.D.

Friday, March 18, 1898.

The PRESIDENT in the Chair.

Specimens.

DR. SMYLY showed a uterus, weighing $9\frac{1}{2}$ lbs., which he had removed for myoma by panhysterectomy. The patient did not complain of any symptoms, but the large tumour, which was uninodular, was in process of enucleation, and a portion of it was protruding through the os uteri, which was dilated to the size of a crown piece. The patient, who had been operated upon three weeks previously, was making an excellent recovery.

He also showed a uterus removed from a patient aged forty-nine. She was a widow, who supported herself and family by farming, but had latterly been unable to work, owing chiefly to pain in her back. The uterus was found retroflexed and adherent. The posterior *cul-de-sac* was opened, and the adhesions partly broken down with the finger, partly divided with scissors. An anterior colpotomy was then performed with a view to vaginal fixation of the uterus, but the hæmorrhage from the divided adhesions was so considerable that it was deemed safer to remove the uterus. Upon examination after removal the organ was found in a state of retroflexion, owing to a hard inflammatory band on its posterior surface, so that had the uterus been fixed in anteversion the constant strain upon this band would doubtless have caused such suffering that her symptoms would have been greatly aggravated. She is now perfectly well, and free from pain.

DR. J. H. GLENN—Myomatous uterus removed by intraperitoneal hysterectomy.

DR. R. D. PUREFOY—Double ovarian cysts.

DR. JELLETT—Early specimen of sarcomatous ovary removed by anterior colpotomy.

Clinical Report of the Rotunda Hospital for three years, 1893-6.

DR. W. J. SMYLY read this Report. [It will be found in Vol. CV., at pages 295 and 383.]

THE PRESIDENT said he was sure that the thanks of the Section were due to Dr. Smyly and his collaborators, Drs. Wilson and Jellett, for the Report. He thought that such results were not likely to be eclipsed for a considerable time. He expressed surprise at the number of cases under the heading of accidental hæmorrhage. In 134 cases of abortion, 50 were curetted, which seemed to be a very large proportion. He congratulated Dr. Smyly on there being no death from placenta prævia. He thought that severe post-partem hæmorrhage, not arising from the situation of the placenta at all, often occurred, and that its origin was often overlooked. He thought that the case in which there was found a double uterus after removal of the uterus, and the subsequent recovery of this patient, was very remarkable.

DR. KNOTT asked how Dr. Smyly had prepared the saline solution used for transfusing.

DR. TWEEDY congratulated Dr. Smyly on his results. He observed that a great many of the deaths were in women brought into the hospital with death symptoms already marked. Three of the five septic cases had evidently become septic outside, and nothing could have saved them. The cases of eclampsia seemed to have been very severe. The giving of morphia in eclampsia was an interesting point. Some observers say that its administration kills the child, but in case No. 7 of Dr. Smyly's the child was alive, although the mother got more morphia than any other case. He (Dr. Tweedy) said that morphia could not kill the child, but killed by acting on the respiratory centre. He noticed that laminaria tents had been used in one of the cases of death after abortion. Did thorough plugging of the vagina not dilate the cervix properly in this case?

DR. LANE congratulated Dr. Smyly on the results of the three years. He could not quite agree with the President in saying that the deaths from accidental hæmorrhage were above the average.

DR. GLENN added his hearty congratulations to Dr. Smyly on the distinctly great improvement from former years, culminating in the wonderfully low death-rate. In reference to curetting in abortions he regarded that as distinctly an evolution. He thought that the use of the sharp curette in the treatment of abortions was,

in skilled hands, quite safe, while for those not so self-confident the use of the blunt instrument was good practice. Dr. Smyly's three fatal cases of incomplete abortion would have died whether curetted or not. He thought that a serious omission, in reference to forceps cases had been made in the Report—viz., there was no record of mortality in regard to the children. He thought that a record of these deaths should also be kept, as it would be of great interest to future generations.

DR. DOYLE considered eclampsia a form of uræmic convulsions. He had not had experience in the treatment of eclampsia with morphia, but had found chloral very useful. He thought that the condition of the kidneys should be found out at the time of the eclamptic convulsions. He concluded by congratulating Dr. Smyly on his results.

DR. SMYLY, in reply, thanked the members for their kindly criticism. In compiling a Report of this kind accuracy was of the first importance, and this he believed was secured by the system employed in the Rotunda. He believed that if the suggestions made by Dr. Glenn were adopted by future reporters they would add to the value of future Reports. He would himself suggest that in addition to noting the total number of cases in which the temperature rose above $100\cdot8^{\circ}$, it would be important to record the number of cases in which the patients were really ill, and those in which it rose on one occasion only. He agreed with Dr. Tweedy that one could not judge of the results of treatment from a small number of cases, and that even large numbers would give an erroneous view, as owing to the rule of the hospital admitting all cases when in labour, a large number were admitted in a condition in which treatment came too late. This was especially evident in the cases of eclampsia and septicæmia. Of the three deaths noted under the former heading, one was in a dying condition when admitted, and he did not believe that the other two could possibly have been saved, certainly not by chloroform.

The Section then adjourned.

SECTION OF PATHOLOGY.

President—J. M. PURSER, M.D.

Sectional Secretary—E. J. McWEENEY, M.D.

Friday, 25th March, 1898.

The PRESIDENT in the Chair.

Traumatic Rupture of Duodenum.

DR. E. H. BENNETT exhibited an example of rupture of the duodenum from a kick of a horse. In the absence of any definite symptoms an exploratory laparotomy was performed without any lesion being discovered. At the *post-mortem* examination it was found that the portion of the duodenum which lay against the spine and outside the peritoneum had been ruptured, and that the intestinal contents had escaped along the spine downwards as far as the pelvis. He commented on the vagueness of the clinical signs of this injury, and its great fatality.

DR. E. J. McWEENEY said that he remembered seeing in the *post-mortem* room a case of traumatic rupture of duodenum, following a chronic, round, clean punched-out duodenal ulcer. In that case the patient had succumbed to an injury—the kick of a horse in the stomach. Immediate collapse followed the injury. Diagnosis of a rupture of some important abdominal viscus was made, but patient was too far gone to allow of operation. The rupture was into the peritoneal cavity, and was attended by acute, diffuse, purulent peritonitis.

DR. E. H. BENNETT, replying, drew attention to the statement of Colin, to whose facts he (Dr. Bennett) had alluded, that the clinical symptoms of such injury are very vague, and of such injuries recorded, only one recovery followed. A second recovery occurred recently in Buda-Pesth, where the abdomen was opened, after the occurrence of peritonitis, three or four days after injury, the abdominal cavity drained, and the wound sutured.

Cancer of Œsophagus—Perforation of Right Subclavian Artery by a Secondary Growth.

DR. J. W. MOORE read a paper on the above disease. [It will be found in Vol. CV., page 396.]

PROFESSOR O'SULLIVAN read an account of the pathology of the case.

DR. CRAIG said that the case was an extremely interesting one. A somewhat similar case came under his care in the past fort-

night, where the primary cancer occurred in the œsophagus just below bifurcation of trachea, the secondary growths occurring in many places. A large growth occupied the lesser omentum, extending from the posterior wall of the lesser curvature of stomach to the under surface of liver; a lower growth surrounded the aorta, and was adherent to the vertebral column. There were small growths in liver, lungs completely studded with small tumours, and epiglottis also involved; and, although vocal chords and larynx were not involved, there was behind and on edges of epiglottis a new growth—a squamous epithelioma. In his experience of such cases, in nearly all of them the growth involved that part of œsophagus which lies opposite the bifurcation of trachea.

DR. M'CAUSLAND asked if a bougie had been passed more than once? Was any blood or matter noticed on withdrawal of bougie? Was any obstruction noticed? Was the vomited matter ever examined microscopically, and would such examination throw any light on the diagnosis? Was any reason assigned for the fœtid expectoration? His experience was that cancer in the lung gave rise to very fœtid expectoration and marked symptoms.

DR. E. J. MCWEENEY agreed with Dr. Craig in saying that the favourite place for cancer of the œsophagus is about bifurcation of trachea. Last week he made a *post-mortem* in a case of cancer of the œsophagus corresponding to bifurcation of the trachea. The left bronchus was adherent to the thickened portion of the œsophagus, and although the œsophagus itself was ulcerated and thickened, there was not the slightest attempt at ulceration of the bronchus, and although there was a big packet of lymphatic glands wedged in between the structures in this situation, careful examination revealed not the slightest evidence of cancerous deposition in any one of them. They were all black, and appeared to be infiltrated with carbonaceous pigment from the lungs. It was thus interesting to note how completely limited cancer may be to the mucous membrane of the œsophagus itself without spreading to such eminently attackable structures by epithelioma as the nearest lymphatic glands.

DR. KNOTT had seen Dr. Moore's case, and could confirm his difficulty about the diagnosis. About a hundred years ago, when disease of œsophagus was rare, the upper third of œsophagus was laid down by all authorities to be the most favourite seat for cancer which was scirrhus. Later German statistics showed that the common seat was at the lower end, and was always epithelioma. He asked Dr. Moore what was his experience of secondary growth as limited to œsophagus. He had heard it laid down by some

authorities that foetid expectoration is never characteristic of cancer of the lung.

DR. MOORE, in reply, said that the bougie had been passed only once before the case came under his observation, and the passage of the bougie produced a remarkable amelioration in the symptom of dysphagia. However, he forbade further attempts to pass it, as he came to the conclusion that a thoracic aneurysm was present. With regard to the expectoration, he concluded that that was another evidence of intrathoracic aneurysm, that the pressure was exercised on the nutrient vessels of left lung in which there were distinct physical signs. In answer to Dr. Knott he said that there was no evidence of involvement of the lung in the cancerous growth at all. He added that the mode of death seemed to him to confirm the diagnosis of aneurysm, which was first called in question by the X-rays examination, which revealed no aneurysmal tumour.

Bones Removed in Case of Fracture of Skull.

MR. WHEELER exhibited a patient, and bones removed, trephined for depressed fracture of skull.

C. M., aged twenty-nine, occupation a coachman, was admitted into the City of Dublin Hospital on the 21st March, 1897, having sustained a severe injury to his head, caused by a fall from the top of an electric tramcar while in motion. The patient's condition on admission was that of profound coma, he was completely paralysed, and his respirations were stertorous, his pulse was laboured and slow, 50 per minute; the surface of his body was warm and perspiring; both his pupils were dilated, his reflexes were absent; his faeces and urine were retained; there was no hæmorrhage from his ear, mouth, or nose. A large depression could be easily detected upon the left side of his head, in front of the parietal eminence.

A large V-shaped flap was raised, the hair having been previously removed and the soft parts thoroughly cleansed. This exposed the depressed area of bone, which was at the junction of the parietal and sagittal sutures, and there was brought into view an extensive comminuted fracture invading both frontal and parietal bones. A large triangular piece of bone was removed, and two smaller pieces with several spicula. From the superior portion of this large triangular piece of bone the superior longitudinal sinus had to be separated. There was considerable hæmorrhage from a large cerebral vessel as well as from wounds in the dura mater. Ten minutes after the operation the patient conversed with his master, a Doctor of Medicine living in Merrion-square. It is not

necessary to detail the daily progress of this patient, who has quite recovered, except for the loss of sight in his left eye.

After the operation, and for days after, he could see tolerably well with his left eye; his field of vision was impaired, and occasionally there was a "blur," to use his own phraseology, over and round objects he looked at. During this period there could not be ascertained by transmitted light anything abnormal with the fundus or with his optic disc, yet his pupil contracted when his eye was closed and dilated widely when his eye was opened, or when he opened it himself by request. There was no ptosis. There was not any inequality in his pupils previous to the dilatation of his left pupil observed on exposure to light. There was not any sluggish reaction of the right pupil on a strong beam of light being thrown into his left eye. There was not any contraction followed by dilatation, or oscillations of any kind; his pupil remained dilated. The so-called paradoxical pupil is diagnostic of early paralysis, and consists in this—that when a strong beam of light is thrown into the eye with the focal illumination, the pupil at first contracts fairly well, then dilates slightly, contracts again, and after a few such oscillations finally dilates widely, although the strong light still shines into the eye. There is no paralysis in this case.

Traumatic Rupture of Liver and Kidney.

MR. WHEELER related the history of a child, aged six years, who was run over by a cart, causing rupture of the liver and right kidney, both shown. The child was admitted to the City of Dublin Hospital on March 10th, 1898, at 3 30 p.m., apparently with little the matter, as it ran about the accident ward. There was no external mark. At 4 15, the child, lying in its bed, was observed to get weak, and shortly after exhibited all the signs of collapse; three hours after it died.

The liver presented a contused appearance. On the upper surface and posterior portion of the right lobe, towards the anterior right margin, was a linear rupture, with the capsule torn about $\frac{3}{4}$ of an inch. Between this and right border, near the right lateral ligament, there was an angular gaping rupture, $2\frac{1}{2}$ to 3 inches long, communicating about the centre with the posterior surface and extending round the right margin. Upon the under surface of the right lobe, corresponding to the depression for the kidney, was a long irregular rupture, gaping slightly and extending at one portion into the rupture on the superior surface.

The right kidney presented upon the anterior surface three long

gaping ruptures, two of which passed round its inner border and extended posteriorly, the third extended to the outer border and deeply into the kidney substance. Upon the posterior surface, as well as the two ruptures mentioned, there were about its centre several minute ruptures which were covered by the unbroken capsule. The child passed urine on admission; there was no blood passed with the urine. Although the *post-mortem* examination revealed a large blood-clot in the urinary bladder, there was a large quantity of blood in the peritoneum. The vessels of the kidney were not injured.

MR. T. MYLES said that Mr. Wheeler's second case showed the great obscurity of the symptoms. It was astonishing to note the extraordinary amount of liver shattering that may exist, and be for a time unaccompanied with any severe symptoms. He related the case of a man who got squeezed between buffers on the railway, but had sufficient strength to walk a considerable distance before feeling weak. He was then driven to hospital and put to bed. Soon afterwards he developed some collapse and slight tenderness, and stated that it hurt him to draw a deep breath. Three days afterwards, in a moment of anger—he was sitting up in bed at the time—he snatched up a pillow and threw it, and immediately gave a violent yell, lay back, and was dead in half an hour. *Post mortem* showed the whole abdominal cavity full of blood, three vertical fissures in liver, one extending half way through its substance. Two of them had absolutely united, but the third had apparently been torn open by the sudden muscular effort. He related a remarkable case where a man sustained an abdominal injury, but was able to walk some distance to hospital, assisted by some friends. He vomited blood very freely, and became moderately collapsed. Death occurred in twenty-four hours. *Post mortem* showed the small intestine cut clean across as if cut with a sharp knife, the cut extending for some inches through the mesentery. The right external iliac artery was torn, and a huge extravasation of blood surrounded it. His liver was turned into a regular jelly, and was utterly unrecognisable, and his fifth lumbar vertebra was dislocated half way back behind the fourth. Death was due to shock. It was probable, he said, that in the "wind contusion" death was due to traumatic rupture of liver due to the gliding action of the cannon ball shattering and rupturing the liver, without any external mark of violence.

DR. E. J. MCWEENEY said that about a fortnight ago he had made a *post-mortem* examination on a man with rupture of liver caused a fortnight previously. A cart-wheel had passed over

thorax, and the right lung was ruptured, giving rise to a suppurating gangrenous cavity in its substance, and the liver below the diaphragm was ruptured in the most convex part of the right lobe for some inches into the depth of its substance. For several inches along the surface, corresponding to this rupture, the diaphragm had been detached from the liver, leaving a space filled with pus, blood, and bile. On washing away the stuff, the walls were of a brilliant yellow hue, due to bile staining, but the contents were of a brown colour, apparently due to blood and pus, as suppuration had taken place. Death was due to septic absorption. There was nothing whatever in the clinical symptoms to cause a surgeon to suspect rupture of the liver. All the interest was in connection with the lung.

MR. WHEELER, in reply, said that his own case recalled to his mind the case of a man who received a kick in the abdomen. As soon as collapse was over and reaction established, he tied a branch of the cœliac axis artery in the abdomen. He had seen an example of "wind contusion" mentioned by Mr. Myles, where a man got a six-pounder ball across him. The man walked for a mile and a half. There was not an abrasion on the skin, and his liver, spleen, and kidney were ruptured. Death ensued.

Sarcoma of the Sphenoid.

MR. WHEELER showed a large sarcomatous tumour—originating in the sphenoid bone—removed from a male patient, aged twenty-five years, whose history was as follows:—

A tall, well-formed man, by occupation a carpenter, was admitted into the City of Dublin Hospital, on October 18th, 1897. He had suffered from inflammation of his right middle ear, consequent upon which he had perforation of his tympanum, and some discharge; he had slight facial paralysis, accompanied with a "scalding" pain in the right side of the face; he had tenderness and pain over his right mastoid region—some rigidity of his masseter muscles; there was no vomiting, no unsteadiness of his gait; there was no eye trouble, nor did examination reveal anything abnormal in his eyes. Mr. Wheeler trephined this patient by his own operation, in December, 1897, opening the mastoid cells, the tympanum, and exposing the dura mater, at the upper arc of the trephine circle, which allowed the temporal lobe to be explored. The patient recovered rapidly and progressed to convalescence, feeling much relieved from the pain. The discharge ceased, and there was less contraction of his masseter muscles, the scalding pains in his right face were very much lessened, but the facial paralysis remained unaltered.

In February, 1898, the scalding feeling and pain again troubled him. His masseter muscles again became rigid and contracted, and he now complained of pain in the temporal region anterior and on a level with the superior margin of his ear. The history of his case told that he had received an injury in this situation by a brick falling upon his head, while he was following his occupation as a carpenter in an unfinished house. The possibility of a cerebellar abscess was thought of, but there was not sufficient evidence to verify such a conclusion. There was nothing that could be found by ophthalmic examination to indicate tumour of the brain; his eyes were normal. He was trephined (by Mr. Wheeler) over the seat of his pain upon March 3rd, 1898. A careful examination was followed by a negative result; the man expressed himself much relieved from his pain, which had been acute; he lived until March 8th, and apparently died of pressure on the region of the medulla.

An examination was made, and a rounded nodular tumour was seen bulging into the middle fossa on the right side, extending into the sphenoidal fissure, and posteriorly to the petrous portion of the temporal bone for about $1\frac{1}{2}$ inch, its superior surface being on a level with the anterior-clinoid process; continuing inwards it occupied the space between the anterior and the posterior clinoid process of the right side, extending beyond the middle line; posteriorly a nodule could be seen lying under the fifth nerve, and internally to this a large nodule encircling the sixth nerve as it passes the dura-mater; the carotid arteries were surrounded by this growth, and the third nerve passed into it. The tumour was of vast extent, pressing into the ethmoid bone in front, and into the pterygoid regions on the right side, behind it involved the basilar process of the occipital bone and the occipito-atlantoid joints. The specimen was interesting, taking into consideration the absence of all eye trouble, notwithstanding that the third, fourth, fifth, and sixth nerves passed through the tumour. Two days before the operation of March 3rd, this patient walked about the ward and sat in a chair for two hours.

Dr. McWeeney, who kindly examined the tumour, reports as follows:—

“This tumour is a large round-celled sarcoma. In places there are trabeculæ of very dense, almost structureless, and more or less hyaline tissue, which give the structure a resemblance to cylindroma. This tough structureless material was probably the dura-mater.”

DR. E. J. McWEENEY had made a microscopic examination of the tumour; the tumour consisted of sarcoma tissue, partly round and partly spindle-celled. There was rather a curious appearance,

due to the presence in the tumour of bands of very tough, almost hyaline connective tissue, which cut up the sarcoma in places into alveolar-looking masses which almost suggested a cancer. The tumour was sarcomatous in nature. He thought, on the whole, that the strands were dura-matral, tough and degenerate, and separated from each other by the cells of the tumour.

MR. T. MYLES asked if any of the physicians present could tell him whether it is ever possible to make an accurate diagnosis of cerebral tumour. As to the surgical side the diagnosis is extremely difficult. He had a good while ago seen a case in Steevens' Hospital with obscure nervous symptoms. A great many medical men thought that the case coincided with Professor Charcot's description of disseminated sclerosis. *Post-mortem* examination soon afterwards disclosed a cerebellar tumour without any disseminated sclerosis.

Note on a Specimen of Complete Osseous Union of Transverse Fracture of Patella.

DR. JOHN KNOTT read notes of a case on this subject.

DR. E. H. BENNETT said that the specimen was as complete as any he had seen; it corresponded very closely indeed with the magazine plates in which there is a specimen almost identical with Dr. Knott's.

MR. MYLES, on examining the specimen, questioned whether the line of fracture along the cartilages represented a complete cleft through the entire thickening of the bone, whether it was not only a chip out of part of the bone.

SIR WILLIAM STOKES thought that there was a distinct mark of the fracture in the front of Dr. Knott's specimen.

MR. WHEELER said he had shown a specimen of bony union of the patella a good many years ago, at the Pathological Section in T.C.D. The specimen was obtained two years after the sustained injury, when death occurred from phthisis.

DR. E. H. BENNETT said that he had seen Mr. Wheeler's specimen. His specimen was one of comminuted fracture of the patella, the bone being broken into three pieces, and not a transverse fracture; such specimens were common.

DR. KNOTT having replied,

The Section then adjourned.

SANITARY AND METEOROLOGICAL NOTES.

Compiled by J. W. MOORE, B.A., M.D., Univ. Dubl. ;
F.R.C.P.I. ; F. R. Met. Soc. ;
Diplomate in State Medicine and ex-Sch. Trin. Coll. Dubl.

VITAL STATISTICS

For four weeks ending Saturday, June 18, 1898.

The deaths registered in each of the four weeks in the twenty-three principal Town Districts of Ireland, alphabetically arranged, corresponded to the following annual rates per 1,000 :—

TOWNS	Weeks ending				Average Rate for 4 weeks	TOWNS	Weeks ending				Average Rate for 4 weeks
	May 28	June 4	June 11	June 18			May 28	June 4	June 11	June 18	
23 Town Districts	22.1	20.9	23.9	19.6	21.6	Limerick -	22.5	16.8	35.1	15.4	22.4
Armagh -	7.1	21.4	7.1	21.4	14.3	Lisburn -	29.8	12.8	33.3	8.5	22.3
Ballymena	11.3	16.9	5.6	16.9	12.7	Londonderry	20.4	15.7	17.3	18.8	18.1
Belfast -	22.8	25.3	24.0	19.7	22.9	Lurgan -	18.2	13.7	18.2	9.1	14.8
Carrickfergus	5.8	5.8	11.7	23.4	11.7	Newry -	12.1	16.1	4.0	12.1	11.1
Clonmel -	19.5	24.3	24.3	19.5	21.9	Newtownards	34.0	0.0	34.0	45.4	23.3
Cork -	19.4	24.2	27.0	14.5	21.3	Portadown	43.3	18.6	30.9	0.0	23.2
Drogheda -	22.8	11.4	19.0	19.0	18.1	Queenstown	23.0	28.7	17.2	11.5	20.1
Dublin -	22.2	19.2	24.0	21.0	21.6	Sligo -	60.9	35.5	15.2	20.3	33.0
Dundalk -	12.6	8.4	12.6	12.6	11.6	Tralee -	11.2	16.8	22.4	11.2	15.4
Galway -	18.9	18.9	15.1	30.2	20.8	Waterford	21.9	17.9	37.8	27.9	26.4
Kilkenny -	14.2	23.6	33.0	23.6	23.6	Wexford -	36.1	27.1	13.5	27.1	25.9

In the week ending Saturday, May 28, 1898, the mortality in thirty-three large English towns, including London (in which the rate was 16.0), was equal to an average annual death-rate of 16.5 per 1,000 persons living. The average rate for eight principal towns of Scotland was 21.4 per 1,000. In Glasgow the rate was 23.3. In Edinburgh it was 19.5.

The average annual death-rate represented by the deaths registered during the week in the twenty-three principal town districts of Ireland was 22·1 per 1,000 of their aggregate population, which, for the purpose of this return, is estimated at 1,007,798.

The deaths from the principal zymotic diseases in the twenty-three districts were equal to an annual rate of 2·2 per 1,000, the rates varying from 0·0 in eighteen of the districts to 4·5 in Belfast—the 133 deaths from all causes registered in that district comprising 1 from measles, 1 from scarlatina, 1 from whooping-cough, 2 from diphtheria, 2 from simple continued fever, 15 from enteric fever, and 4 from diarrhœa. The 28 deaths in Cork comprise 1 from typhus and 1 from diarrhœa.

In the Dublin Registration District the births registered amounted to 203—107 boys and 96 girls; and the registered deaths to 155—83 males and 72 females.

The deaths, which are 10 under the average number for the corresponding week of the last ten years, represent an annual rate of mortality of 23·1 in every 1,000 of the population. Omitting the deaths (numbering 6) of persons admitted into public institutions from localities outside the district, the rate was 22·2 per 1,000. During the twenty-one weeks of the current year the death-rate averaged 29·3, and was 1·2 under the mean rate in the corresponding period of the ten years 1888–1897.

As in the preceding week, only 15 deaths from zymotic diseases were registered. The number is 3 under the average for the twenty-first week of the last ten years. The 15 deaths consist of 1 from measles, 1 from scarlet fever (scarlatina), 1 from influenza, 3 from whooping-cough, 4 from diphtheria, 3 from enteric fever, 1 from dysentery, and 1 from diarrhœa.

Twenty-one cases of scarlatina were admitted to hospital, being 1 over the admissions in the preceding week and 6 over those in the week ended May 14th. Thirty-three scarlatina patients were discharged, and 143 remained under treatment on Saturday, being 12 under the number in hospital at the close of the preceding week. There were, in addition, 21 convalescents at Beneavin, the Convalescent Home of Cork-street Fever Hospital.

Seventeen cases of enteric fever were admitted to hospital, against 14 in the preceding week. Thirteen patients were discharged, 2 died, and 75 remained under treatment on Saturday, being 2 over the number in hospital on that day week.

The hospital admissions for the week included also 2 cases of typhus—the only cases of that disease in hospital on Saturday.

Diseases of the respiratory system caused 27 deaths, being 5

over the number for the preceding week, and equal to the average for the twenty-first week of the last ten years. The 27 deaths comprise 16 from bronchitis and 10 from pneumonia.

In the week ending Saturday, June 4, the mortality in thirty-three large English towns, including London (in which the rate was 16·1), was equal to an average annual death-rate of 16·8 per 1,000 persons living. The average rate for eight principal towns of Scotland was 23·0 per 1,000. In Glasgow the rate was 23·1, and in Edinburgh it was 23·7.

The average annual death-rate in the twenty-three principal town districts of Ireland was 20·9 per 1,000 of their aggregate population.

The deaths from the principal zymotic diseases in the twenty-three districts were equal to an annual rate of 1·9 per 1,000, the rates varying from 0·0 in fourteen of the districts to 9·4 in Kilkenny—the 5 deaths from all causes registered in that district comprising 2 from scarlatina. Among the 148 deaths from all causes registered in Belfast are 1 from measles, 1 from scarlatina, 3 from whooping-cough, 1 from diphtheria, 1 from simple continued fever, 10 from enteric fever, and 2 from diarrhœa.

In the Dublin Registration District the registered births amounted to 242—125 boys and 117 girls; and the registered deaths to 132—54 males and 78 females.

The deaths, which are 31 under the average number for the corresponding week of the last ten years, represent an annual rate of mortality of 19·7 in every 1,000 of the population. Omitting the deaths (numbering 3) of persons admitted into public institutions from localities outside the district, the rate was 19·2 per 1,000. During the twenty-two weeks of the current year the death-rate averaged 28·9, and was 1·3 under the mean rate in the corresponding period of the ten years 1888–1897.

Only 14 deaths from zymotic diseases were registered, being 1 under the low number for each of the two weeks preceding, and 5 below the average for the twenty-second week of the last ten years. They comprise 1 from scarlet fever (scarlatina), 1 from influenza 5 from whooping-cough, 2 from enteric fever, 2 from diarrhœa, and 1 from erysipelas.

The number of cases of scarlatina admitted to hospital was 18, being 3 under the admissions for the preceding week, and 2 under the number for the week ended May 21. Twenty-four scarlatina patients were discharged, 1 died, and 136 remained under treatment on Saturday, being 7 under the number in hospital at the

close of the preceding week. This number is exclusive of 21 convalescents at Beneavin.

Only 10 cases of enteric fever were admitted to hospital, being a decline of 7 as compared with the admissions in the preceding week. Nine patients were discharged, 1 died, and 75 remained under treatment on Saturday, being equal to the number in hospital on that day week.

Deaths from diseases of the respiratory system fell to 16, or 12 under the average for the corresponding week of the last ten years. The 16 deaths comprise 8 from bronchitis and 6 from pneumonia.

In the week ending Saturday, June 11, the mortality in thirty-three large English towns, including London (in which the rate was 16·3), was equal to an average annual death-rate of 16·9 per 1,000 persons living. The average rate for eight principal towns of Scotland was 21·3 per 1,000. In Glasgow the rate was 23·3, and in Edinburgh it was 21·1.

The average annual death-rate in the twenty-three principal town districts of Ireland was 23·9 per 1,000 of the population.

The deaths from the principal zymotic diseases in the twenty-three districts were equal to an annual rate of 1·6 per 1,000, the rates varying from 0·0 in sixteen of the districts to 7·1 in Armagh—the only death registered in that district having been caused by diphtheria. Among the 140 deaths from all causes registered in Belfast are 2 from whooping-cough, 16 from enteric fever, and 3 from diarrhœa.

In the Dublin Registration District the registered births amounted to 207—107 boys and 100 girls; and the registered deaths to 168—79 males and 89 females.

The deaths, which are 17 over the average number for the corresponding week of the last ten years, represent an annual rate of mortality of 25·1 in every 1,000 of the population. Omitting the deaths (numbering 7) of persons admitted into public institutions from localities outside the district, the rate was 24·0 per 1,000. During the first twenty-three weeks of the present year the death-rate averaged 28·7, and was 1·2 under the mean rate in the corresponding period of the ten years 1888–1897.

Only 10 deaths from zymotic diseases were registered, being 4 under the low number for the preceding week, and 7 below the average for the twenty-third week of the last ten years. They comprise 4 from influenza and its complications, 2 from whooping-cough, 1 from cerebro-spinal meningitis, 1 from enteric fever, and 1 from diarrhœa.

Twenty-two cases of scarlatina were admitted to hospital, being 4 over the admissions in the preceding week. Twenty-five scarlatina patients were discharged, 1 died, and 132 remained under treatment on Saturday, being 4 under the number in hospital at the close of the preceding week. There were 20 convalescents, in addition, at Beneavin, Glasnevin.

The number of cases of enteric fever admitted to hospital rose to 20. Eighteen patients were discharged, and 77 remained under treatment on Saturday, being 2 over the number in hospital at the close of the preceding week.

Diseases of the respiratory system caused 30 deaths, being 14 over the number for the preceding week, and 5 over the average for the corresponding week of the last ten years. The 30 deaths consist of 18 from bronchitis, 9 from pneumonia, and 3 from croup.

In the week ending Saturday, June 18, the mortality in thirty-three large English towns, including London (in which the rate was 13·8), was equal to an average annual death-rate of 14·7 per 1,000 persons living. The average rate for eight principal towns of Scotland was 20·2 per 1,000. In Glasgow the rate was 21·2 per 1,000, and in Edinburgh it was 19·2.

The average annual death-rate represented by the deaths registered in the twenty-three principal town districts of Ireland was 19·6 per 1,000 of the population.

The deaths from the principal zymotic diseases in the twenty-three districts were equal to an annual rate of 1·2 per 1,000, the rates varying from 0·0 in eighteen of the districts to 7·1 in Armagh—the 3 deaths from all causes registered in that district comprising 1 from diarrhœa. Among the 115 deaths from all causes registered in Belfast are 1 from measles, 1 from whooping-cough, 2 from diphtheria, 1 from simple continued fever, 6 from enteric fever, and 4 from diarrhœa. The 21 deaths in Cork comprise 1 from typhus and 1 from diarrhœa.

In the Dublin Registration District the registered births amounted to 204—110 boys and 94 girls; and the registered deaths to 147—73 males and 74 females.

The deaths, which are 20 under the average number for the corresponding week of the last ten years, represent an annual rate of mortality of 21·9 in every 1,000 of the population. Omitting the deaths (numbering 6) of persons admitted into public institutions from localities outside the district, the rate was 21·0 per 1,000. During the first twenty-four weeks of 1898 the death-rate averaged 28·4, and was 1·2 under the mean rate in the corresponding period of the ten years 1888–1897.

Only 10 deaths from zymotic diseases were registered, being 9 below the average for the twenty-fourth week of the last ten years. The 10 deaths comprise 1 from whooping-cough, 4 from enteric fever, and 1 from diarrhoea.

The number of cases of scarlatina admitted to hospital was 18, being 4 under the admissions in the preceding week, and equal to the number admitted during the week ended June 4. Thirty scarlatina patients were discharged, and 120 remained under treatment on Saturday, being 12 under the number in hospital at the close of the preceding week. There were besides 16 convalescents at Beneavin, Glasnevin.

The number of cases of enteric fever admitted to hospital fell to 10. Twenty-one patients were discharged, 1 died, and 65 remained under treatment on Saturday, being 12 under the number in hospital on that day week.

Only 15 deaths from diseases of the respiratory system were registered, being 9 below the average for the corresponding week of the last ten years, and 15 under the number for the previous week. They consist of 10 from bronchitis and 5 from pneumonia.

METEOROLOGY.

Abstract of Observations made in the City of Dublin, Lat. 53° 20' N., Long. 6° 15' W., for the Month of June, 1898.

Mean Height of Barometer, -	-	-	29.973 inches.
Maximal Height of Barometer (14th, 9 a.m.), -	-	-	30.357 „
Minimal Height of Barometer (25th, 7 30 a.m.),	-	-	29.330 „
Mean Dry-bulb Temperature, -	-	-	57.4°
Mean Wet-bulb Temperature, -	-	-	53.8°.
Mean Dew-point Temperature, -	-	-	50.4°.
Mean Elastic Force (Tension) of Aqueous Vapour, -	-	-	.368 inch.
Mean Humidity, -	-	-	78.0 per cent.
Highest Temperature in Shade (on 17th), -	-	-	74.9°.
Lowest Temperature in Shade (on 2nd), -	-	-	41.8°.
Lowest Temperature on Grass (Radiation) (on 2nd), -	-	-	39.9°.
Mean Amount of Cloud, -	-	-	58.5 per cent.
Rainfall (on 14 days), -	-	-	1.547 inches.
Greatest Daily Rainfall (on 5th), -	-	-	.429 inch.
General Directions of Wind, -	-	-	S.W., N.W., W.

Remarks.

June, 1898, may be described as an average month. Atmospheric pressure, air temperature, and rainfall were all about the normal value. Like June, 1897, the month must be regarded as a favourable one, conducive to health and propitious to vegetation. It was, however, eminently changeable, and the fluctuations of temperature were abrupt and considerable.

In Dublin the arithmetical mean temperature ($58\cdot0^{\circ}$) was above the average ($57\cdot8^{\circ}$) by $0\cdot2^{\circ}$; the mean dry-bulb readings at 9 a.m. and 9 p.m. were $57\cdot4^{\circ}$. In the thirty-three years ending with 1897, June was coldest in 1882 (M. T. = $55\cdot8^{\circ}$), and in 1879 ("the cold year") (M. T. = $55\cdot9^{\circ}$). It was warmest in 1887 (M. T. = $62\cdot3^{\circ}$); in 1865 (M. T. = $61\cdot0^{\circ}$); and in 1896 (M. T. = $61\cdot4^{\circ}$).

The mean height of the barometer was $29\cdot973$ inches, or $0\cdot056$ inch above the corrected average value for June—namely, $29\cdot917$ inches. The mercury rose to $30\cdot357$ inches at 9 a.m. of the 14th, and fell to $29\cdot330$ inches at 7 30 a.m. of the 25th. The observed range of atmospheric pressure was, therefore, $1\cdot027$ inches.

The mean temperature deduced from daily readings of the dry-bulb thermometer at 9 a.m. and 9 p.m. was $57\cdot4^{\circ}$, or $6\cdot8^{\circ}$ above the value for May, 1898. Using the formula, *Mean Temp.* = *Min.* + (*max.* - *min.* \times $\cdot465$), the value was $57\cdot5^{\circ}$, or $0\cdot3^{\circ}$ above the average mean temperature for June, calculated in the same way, in the twenty-five years, 1865-89, inclusive ($57\cdot2^{\circ}$). The arithmetical mean of the maximal and minimal readings was $58\cdot0^{\circ}$, compared with a twenty-five years' average of $57\cdot8^{\circ}$. On the 17th the thermometer in the screen rose to $74\cdot9^{\circ}$ —wind, W.; on the 2nd the temperature fell to $41\cdot8^{\circ}$ —wind, N. The minimum on the grass was $39\cdot9^{\circ}$, also on the 2nd.

The rainfall amounted to $1\cdot547$ inches, distributed over 14 days. The average rainfall for June in the twenty-five years, 1865-89, inclusive, was $1\cdot817$ inches, and the average number of rainy days was 13·8. The rainfall, therefore, was below, while the rainy days were equal to, the average. In 1878 the rainfall in June was very large— $5\cdot058$ inches on 19 days; in 1879, also, $4\cdot046$ inches fell on 24 days. On the other hand, in 1889, only $\cdot100$ inch was measured on 6 days; in 1887, the rainfall was only $\cdot252$ inch, distributed over only 5 days. In 1897, $3\cdot257$ inches fell on 20 days.

High winds were noted on 8 days, but the force of a gale was on no occasion attained. The atmosphere was more or less foggy on the 8th. Temperature reached or exceeded 70° in the screen on 4 days, compared with 17 days in 1887, only 1 day in 1888,

and 6 days in 1897. A thunderstorm occurred on the 12th, and thunder was heard on the 26th. Hail fell on the 1st and 22nd.

Very unsettled, squally, cold, and showery weather characterised the period ending Saturday, the 4th. The showers were accompanied by thunder and lightning at many British stations on Wednesday, the 1st, and Thursday, the 2nd. This last-named day proved unexpectedly fine and sunny in Ireland, a depression which had advanced from the N.W. having "turned tail" and retreated towards N. and N.W. along the coasts of Denmark and Norway. On Friday, however, a new low pressure area appeared to the northward of Ireland, and this brought about a renewal of unsettled weather. The wind at the same time backed towards S.W. and S., so that there was a distinct advance in temperature, and the period closed with a prospect of more summerlike weather. In Dublin the barometer ranged between 29·669 inches at 9 p.m. of Wednesday (wind, N.W.) and 29·960 inches at 9 p.m. of Thursday (wind, N.W.). On Thursday the screened thermometers fell to 41·8°, on Saturday they rose to 61·8°. The rainfall was ·187 inch on three days, ·124 inch being measured on Saturday. N.W. to S.W. winds prevailed.

Commencing with gloomy, unsettled weather and heavy rains, the week ended Saturday, the 11th, proved fine and summerlike in Ireland and Scotland. In the S.E. of England, however, the weather was kept in an unsettled, dull, and rainy state until Friday by the approach of a shallow depression from the southward on Wednesday. On Sunday morning the barometer was low (29·54 inches at Valentia) off the S.W. of Ireland, southerly winds prevailed, accompanied by rain in many places. On Monday morning a V-shaped depression lay over Ireland, where the weather remained in a broken, rainy condition, while thunder and lightning occurred very generally throughout England. A brisk increase of atmospheric pressure set in as the day advanced, so that by Tuesday morning baric gradients had become very slight over the British Islands, and there were signs of a change to finer and more summerlike conditions. At 8 a.m. of Wednesday a shallow depression was observed over the S.W. and centre of France, moving slowly north-eastwards. This system became stationary over Belgium on Thursday, and caused gloomy wet weather over the English Channel, the S.E. of England, the North of France, Belgium, and Germany. The rainfalls were very heavy in several places, 1·31 inches being registered at the North Foreland on Friday morning and 1·67 inches at Yarmouth. In Ireland beautiful, warm, and summerlike weather was enjoyed on and after Tuesday. In

Dublin the mean atmospheric pressure was 30·014 inches, the barometer ranging from 29·555 inches at 9 a.m. of Monday (wind, S.) to 30·242 inches at 9 a.m. of Thursday (wind, calm). The corrected mean temperature was 57·7°. The mean dry-bulb reading at 9 a.m. and 9 p.m. was 57·5°. The screened thermometers fell to 48·1° on Tuesday, and rose to 71·0° on Saturday. Rain fell on two days to the amount of ·549 inch, ·429 inch being measured on Sunday. Southerly and southeasterly winds predominated.

Except on Sunday and Saturday, very fine weather prevailed in Ireland during the week ended Saturday, the 18th. In England it was dull, cold, and generally unseasonable until Thursday. Early on Sunday very electrical clouds were seen over Dublin, and there was much distant thunder between 9 and 10 a.m. The rolling of thunder began again at midday, and at 2 p.m. there was a heavy thunderstorm to the S.W. of the city, accompanied by drenching rain in places. No rain fell to the S.E., in Fitzwilliam Square the measurement was only ·028 inch, at Glasnevin Botanic Gardens ·060 inch, at the Ordnance Survey Office, Phoenix Park, ·200 inch. The evening was cool and fine. During the storm the higher clouds came from S.E. or S.S.E., the lower stratum drove down from N. or N.N.E. A period of cloudy, cool weather followed, and this in turn gave place to bright, quiet, warm weather, lasting until Friday night. On the day named the thermometer rose to 74·9° in the screen. Saturday was cloudy and blustering, with light showers. The dull, cold weather experienced in England was caused by depressions lying over the South of France, Spain, and Italy, where heavy rains fell. In Dublin the barometer rose to 30·357 inches at 9 a.m. of Tuesday (wind, N.E.) and fell to 30·062 inches at 9 a.m. of Saturday (wind, W.S.W.). Its mean height was 30·251 inches. The corrected mean temperature was 58·6°. The mean dry bulb reading at 9 a.m. and 9 p.m. was 59·6°. The screened thermometers fell to 46·8° on Wednesday and rose to 74·9° on Friday. Rain fell on two days to the amount of ·087 inch, of which ·059 inch was measured on Saturday. Thunder and lightning occurred on Sunday. N.E. and afterwards W. winds prevailed.

Fair and warm at first, the weather during the week ended Saturday, the 25th, gradually became very unsettled, squally, showery, and cold. Only on Sunday and for a short time on Thursday morning was the distribution of atmospheric pressure anticyclonic, and then only in the south. For the rest, progressively deepening depressions passed eastward across the northern parts of the Kingdom, and on Saturday morning the barometer was

down to 29·28 inches at Nairn, and as low as 29·33 inches even in Dublin. Sunday was a fine, warm day—the maximal temperature in Dublin was 72·3°. On Monday the maximum was 72·6°, there were passing showers and fine intervals. Tuesday was fine but cloudy; towards evening temperature gave way fast. Heavy showers of rain and hail fell on Wednesday. Thursday afternoon proved rainy. Friday was rainy to showery and cold, but with intervals of bright sunshine. Rain fell heavily on Saturday forenoon, when the wind drew round to N. In Dublin the mean height of the barometer was 29·757 inches, pressure ranging between 30·167 inches at 9 a.m. of Sunday (wind, N.W.) and 29·330 inches at 7 30 a.m. of Saturday (wind, W.N.W.). The corrected mean temperature was 58·6°. The mean dry-bulb reading at 9 a.m. and 9 p.m. was 57·6°. The screened thermometers rose to 72·6° on Monday and fell to 46·9° on Thursday. Rain fell on five days to the amount of ·659 inch, ·191 inch being measured on Saturday. Westerly winds prevailed.

Generally favourable, yet changeable, was the weather of the closing period of the month—the 26th to the 30th inclusive. At the beginning an atmospheric depression lay exactly over England, where the weather was broken, cold and showery, with hail and thunder in many places. In Ireland northerly winds prevailed, and conditions were more genial. Thunder was heard in Dublin on the evening of Sunday, the 26th. Monday and Tuesday were fine days. On Wednesday shallow depressions, passing eastwards, caused changeable, showery weather. There was, however, a general rise of temperature. Thursday was cloudy, but fine. The extremes of temperature were both recorded on Tuesday—highest, 69·0°; lowest, 46·3°. Rain fell on two days to the amount of ·065 inch, ·051 inch being registered on Wednesday. The barometer rose from 29·647 inches at 9 a.m. of Sunday (wind, N.) to 30·197 inches at 9 p.m. of Thursday (wind, W.N.W.).

The rainfall in Dublin during the six months ending June 30th. amounted to 12·115 inches on 98 days, compared with 13·950 inches on 113 days in 1897, 7·854 inches on 84 days in 1896, 12·282 inches on 80 days in 1895, 14·361 inches on 109 days in 1894, 9·624 inches on 78 days in 1893, 11·770 inches on 97 days in 1892, 8·748 inches on 77 days in 1891, 13·413 inches on 94 days in 1890, only 6·741 inches on 67 days in 1887, and a twenty-five years' average of 12·313 inches on 95·4 days.

At Knockdolian, Greystones, Co. Wicklow, the rainfall was 1·055 inches distributed over 10 days. Of this quantity ·345 inch fell on the 24th. The total fall since January 1 has been

13·500 inches on 88 days, compared with 18·125 inches on 106 days in the first six months of 1897, 7·356 inches on 61 days in the same period of 1896, 14·270 inches on 67 days in 1895, 17·381 inches on 96 days in 1894, and 11·776 inches on 75 days in 1893.

The rainfall at Cloneevin, Killiney, Co Dublin, amounted to 2·03 inches on 15 days. The greatest fall in 24 hours was ·91 inch on the 5th. The average rainfall for June in the 12 years, 1885-1896, was 1·515 inches on 11·7 days. In 1897, 3·59 inches fell on 20 days, in 1896 1·65 inches fell on 13 days. Since January, 1898, 13·10 inches of rain have fallen at this station on 97 days, compared with 14·80 inches on 113 days in the corresponding six months of 1897.

At the National Hospital for Consumption, Newcastle, Co. Wicklow, the rainfall was 2·459 inches on 14 days, compared with 4·078 inches on 15 days in June, 1897. On the 5th, 1·230 inches were measured, and on the 24th, ·352 inch. The maximum temperature in the shade was 73·0° on the 17th, the minimum temperature in the shade was 41·0° on the 2nd and 3rd. At this climatological station the rainfall for the six months ending June 30, amounted to 14·918 inches on 88 days, compared with 18·372 inches on 102 days in the same period of 1897.

LETHAL EFFECT OF CARBOLIC ACID ON AN INFANT.

M. BOZDANIK (*Wiener Medical Presse*) reports a case of fatal poisoning of an infant by the application of a three per cent. lotion of carbolic acid to a circumcision wound. The lotion was applied on cotton wool by the surgeon immediately on the completion of the operation; some hours afterwards the child passed smoky urine; the same evening the wound was redressed with the lotion by the nurse in attendance. Death followed in forty-eight hours from the time of the first dressing.

A METHOD OF EXAMINING THE LARYNX IN INFANTS.

IN this method the infant is supported in the usual position for laryngoscopy. The index finger of the left hand is placed well into the mouth, and the terminal phalanx hooked around the hyoid bone, which is pulled forward. The rest of the finger acts as a tongue-depressor and the knuckle as a gag. The left thumb placed under the chin serves to steady the head. If a small laryngeal mirror be now introduced in the usual way the larynx can be quite easily seen. The method causes no pain.—Lack, *Journal of Lar., Rhin., and Otol.*

PERISCOPE.

A CASE OF BLACK TONGUE.

FELIX SEMON (*The Journal of Lar., Rhin., and Otol.*, March, 1897) reports the case of a man of forty years affected with a large patch of enormously elongated, hair-like, inky black papillæ in the region of the papillæ circumvallatæ. Under the local use of a 5 per cent. ethereal solution of salicylic acid, mixed with a 5 per cent. collodion solution, and followed by an application of peroxide of hydrogen by means of a plug of cotton wool applied to the affected region several times a day, so much improvement had resulted that only the traces of the affection were still visible.

RUPTURE OF THE HEART BY A BLOW WITH A STICK—SURVIVAL FOR OVER THREE HOURS.

ON the 1st December, 1895, notice was received by Surgeon-Major J. B. Gibbons, I.M.S., of a body at the morgue, and the following particulars of the cause of death were furnished by the Superintendent, 2nd Division, Calcutta Police :—"Deceased, a cooly, aged about thirty years, is said to have been struck with a bamboo stick at about 9 30 p.m. (30-11-'95). He fell down immediately on receiving the blow and vomited. He was removed to the Medical College Hospital, where he died at about 12 40 p.m." The *post-mortem* examination was made at 9 a.m. on the 1st December. The body was fairly nourished, rigor mortis present. There were no external marks of violence, except a few slight abrasions. On opening the abdomen the stomach was seen to be greatly distended. There were about 3 ozs. of serous fluid in the peritoneal cavity. The spleen was uninjured and healthy. On removing the front of the thorax the pericardial sac was found full of blood partly clotted. Fourteen ounces were measured. The heart was contracted, and there was a small irregular-shaped rupture in the apex, communicating with the right ventricle. The cavities of the heart were nearly empty. The rupture was about $\frac{1}{4}$ inch long, irregular in shape, which (and the contracted state of the organ) prevented exact measurement. The muscle fibres appeared quite healthy, and the wall of the right ventricle of usual thickness, except at the apex, where, at the site of the rupture, the

layer of muscle was very thin—much thinner than in another heart examined at the same time. I estimated the thickness of muscle fibre to be equal to that of stout brown paper. The muscle about the rupture was healthy, and there were no signs of myocarditis, recent or of old standing. The quantity of fat on the heart was small, as is usual in men of the class to which deceased belonged; arteries and valves of the heart quite healthy.—*Indian Medical Gazette*.

TOXIC EFFECTS OF ALKALINE LYE.

Two cases of severe stricture following the corrosive action of lye has been judged unmanageable by treatment with sounds by a number of physicians and surgeons. Following the practice of König and others, Zeehnisen had silver balls prepared of a diameter ranging from 2 to 7 mm. A silk thread was passed through a central hole in each of these, and the smallest ball was swallowed at night as far as it would go, the thread being fastened above. Next morning the ball was found to have passed into the stomach, and was withdrawn. The process was repeated, with increasing size of silver balls, and in each case, with ambulatory treatment, the patient advanced to such a condition that a large tube could be readily passed into the stomach.—*Centralblatt für innere Medicin*.

A VALUABLE GIFT.

DR. NICHOLAS SENN has recently presented to the Newberry Library, Chicago, the library of the late Professor Du Bois Reymond, consisting of 4,000 volumes and 13,000 pamphlets, mostly on the subject of physiology. Dr. Senn had previously presented to the same institution the library of Dr. Wilhelm B. Baum, of Göttingen, and many valuable works from his private collection, including the manuscripts of some sixty works from his own hand. At present the medical department of the library consists of over 30,000 volumes and 22,000 pamphlets, and over 400 periodicals embracing all departments of medical science *Philadelphia Medical Journal*.

A PROLIFIC RACE.

THE size of families appears to be attracting some attention in Germany. It is also a question not without importance in this country. In Berlin the Municipal Year-Book for 1896, just issued, gives some curious facts concerning the size of families in that city. In that year a lady presented her husband with

his twentieth living child ; other families numbered 19, 18, and 17 ; while 32 registered their sixteenth, 63 their fifteenth, 83 their fourteenth, and no fewer than 126 their thirteenth child. In spite of these statistics, however, early marriages are rarer in Berlin than in London. The husbands under 20 years of age in 1896 were 62, and only 63 wives were under 17.

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ERRATUM.—In the July number, page 45, line 3 from top of page, for "*dissipere*," read "*desipere*."

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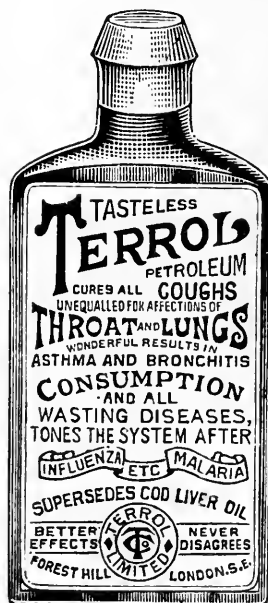
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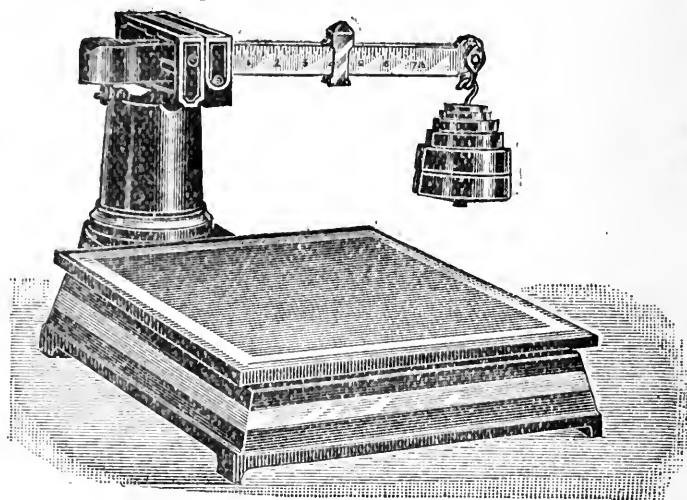
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Height.		MAN.		WOMAN.		Age.	BOY.		GIRL.	
Ft.	in.	St.	lb.	St.	lb.	Years.	St.	lb.	St.	lb.
4	10	7	0	5	3	8	2	12
4	11	7	4	6	3	12	3	1
5	0	...	...	7	7	7	4	1	3	6
5	1	...	...	7	12	8	4	4	3	10
5	2	9	0	8	2	9	4	9	4	1
5	3	9	7	8	9	10	4	13	4	6
5	4	9	13	9	2	11	5	3	4	13
5	5	10	2	9	9	12	5	9	5	8
5	6	10	5	9	13	13	6	0	6	5
5	7	10	8	10	8	14	6	8	7	0
5	8	11	1	11	4	15	7	5	7	8
5	9	11	8
5	10	12	1
5	11	12	6
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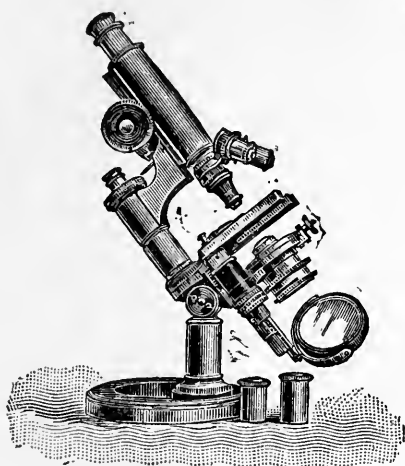
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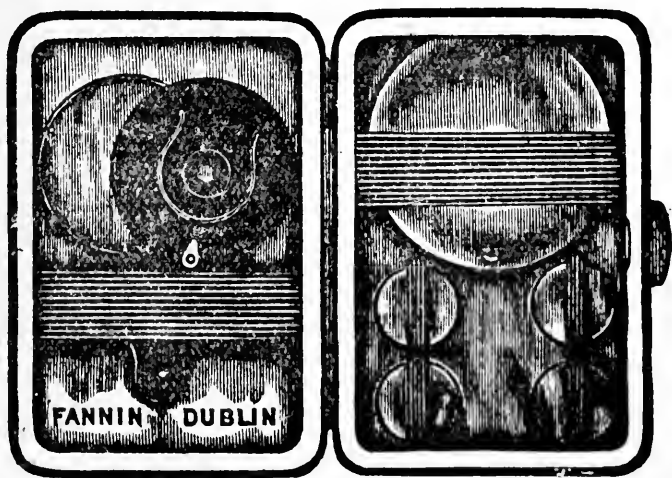
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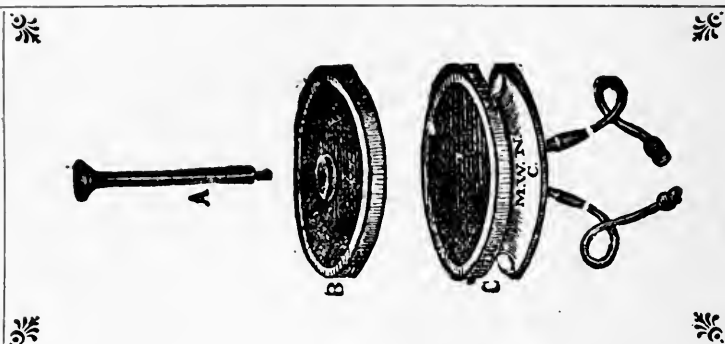
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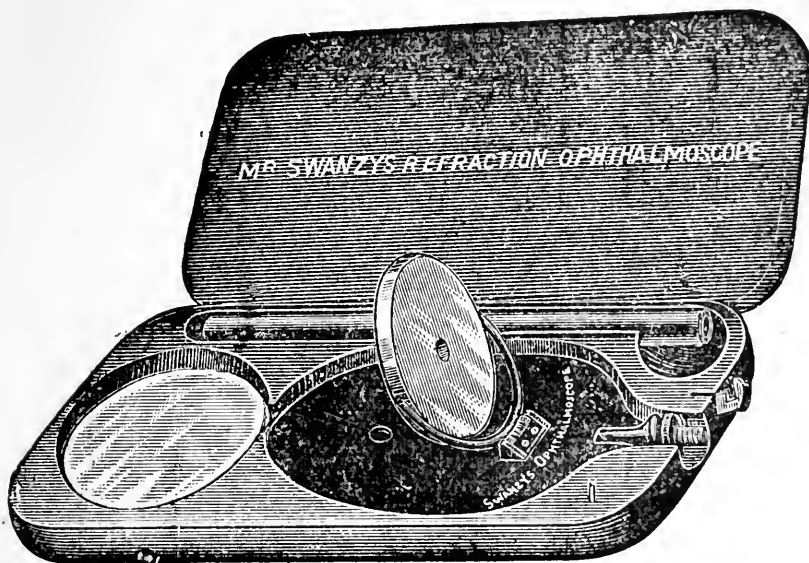
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